Grant No. 367-G-97-
submitted by ADRA Nepal
to USAID/Nepal 10

ADRA
NEPAL

INTEGRATED COMMUNITY BASED FAMILY HEALTH PROGRAM

Kavre and Rasuwa Districts

FINAL REPORT

July, 1997-June, 2002

Submitted to:
USAID

PART I

Report Synthesis

This is the final report produced by the **Integrated Community Based Family Health Program** to report the achievements made during the project period of July 1997 to June 2002. The report is divided into five parts. Parts two to four deal with a description of the program highlighting the achievement of qualitative outcomes and some short term impacts of the program while part five contains ANNEXES in a tabulated form illustrating the output of the program in numerical form.

As the program has ended its fifth and final year there are many indications that suggest the program successfully reached its overall goal of reducing fertility and improving maternal and child health in the targeted areas. Utilizing six inter-related and synergistic strategies, along with three key interventions charted out in the program design at the outset, several notable accomplishments have been achieved. Quantitative data of cumulative accomplishment to the end June 2002 shows very satisfactory figures in terms of program coverage.

The report highlights the achievements made in both the program districts of Kavre and Rasuwa separately. The district report separately describes the Field Activities, Field Training, VDC Health Empowerment, Women's Literacy, Family Planning Training, and FP/PHC service delivery focusing target/achievements, reasons for deviations, and report of investigations if any.

Achievement of program objectives in Kavre and Rasuwa has been satisfactory. The project was successful in reaching the overall goal. An estimated 200,000 population in Kavre (approximately 60% of the district population) and 45,000 in Rasuwa district have benefited directly or indirectly from the program. Similarly, about 42,000 under five children and 62,000 MWRA in both districts were reached through various FP/MCH related activities.

Through its well-recognized FP training intervention at national level the project successfully trained 379 health personnel in clinical and non-clinical family planning trainings, thereby supplementing and strengthening government and non-government health service delivery throughout the country.

Generation of awareness, creating demand, and provision of quality maternal and child health care services has been very successful. Increasing numbers of clients visiting the static clinics in Kavre and Rasuwa speaks volumes for the quality services made available to the population. Because of a continuous focus on quality assurance at every level, the program has been able to maintain a satisfied client/patient base, resulting in a sustained client flow. FP/PHC in Kavre was successful in providing year-round surgical contraception thus significantly reducing the dependency upon periodic, seasonal family planning camps. Significant progress has been achieved in making the FP/MCH services accessible to the underserved populations of both districts through mobile outreach clinics. The program has achieved an average CPR of 61% in its program area of Kavre, well above the district average of 48% and national average of 39%. The project was able to earn 96,800 CYPs of 95,000 targeted. There is evidence of increased knowledge about health and several positive changes in the health behaviors of women. Several components of the program have helped to establish or set a process to achieve long-term sustainability of changed health behaviors. The

very backbone of the program, the community health volunteers, maintained their high performance at the community level. Regular training and effective mobilization of community health volunteers has achieved a positive impact at the grassroots level.

The tendency of pregnant women to seek ANC/PNC check-ups has increased. The mother's groups are holding their monthly meetings. The ARI FCHVs in Rasuwa have treated a large number of ARI cases and helped significantly to reduce child mortality and morbidity in the district. The TTBAs have continued their contacts with the pregnant women and provide basic safe motherhood services to the needy women. Sustained use of SDKs in the program areas suggests positive behavioral change among TTBAs and mothers as well. Community awareness activities such as health quiz contests, celebration of major important days, and street dramas have been able to generate greater enthusiasm among target groups, thus attracting larger audiences.

The women's literacy program is making a positive impact on the community. About 13,650 women of reproductive age in Kavre and Rasuwa have not only become literate but also were equipped with valuable tools which will aid in the improvement of their families' health. There are many evidences to illustrate positive health behavioral change among literacy participants and their families.

The Village Development Committee Health Empowerment Program has been able to equip communities with essential organization skills, which are needed to plan, implement, monitor, and sustain health service delivery at the villages in which they reside. Sixty-five VDCs both in Kavre and Rasuwa district have been trained to independently supervise annual health-related activities through sub-health post support committees. This component of the program is set to ensure long-term program sustainability at the community level as well as foster enough skills for self-reliance, a further step towards attaining full decentralization.

(See report for details)

TABLE OF CONTENTS **Page**

List of Tables **Page**

List of Figures

List of ANNEXES

List of Acronyms/Abbreviations Used

ADRA	Adventist Development and Relief Agency
AHW	Auxiliary Health Worker
ANC	Ante Natal Check-up
ANM	Auxiliary Nurse Midwives
ARI	Acute Respiratory Infection
BLL/P	Basic Literacy Level/Program
CDD	Control of Diarrheal Diseases
CHWs	Community Health Workers
CMA	Community Medical Assistant
COFP/C	Comprehensive FP/Counseling
CPR	Contraceptive Prevalence rate
CYP	Couple Year Protection
DHO	District Health Office
EPI	Expanded Program for Immunization
FC	FP Counselor
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FP	Family Planning
FP/PHC	FP/Primary Health Care
FPTC	Family Planning Training Center
FR	Field Representative
GO	Governmental Organization
HP	Health Post
HVB	Hepatitis Virus B
ICBFHP	Integrated Community Based Family Health Program
IMR	Infant Mortality Rate
IUCD	Inter Uterine Contraceptive Device
LOCEC	*Life Oriented Continued Education Component*
MCH	Maternal and Child Health
MCHW	Maternal Child Health Worker
MERS	Monitoring Evaluation and Research Section
MGM	*Mother's Group Meeting*
ML/LA	Minilaparotomy under Local Anesthesia
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MWRA	Married Women of Reproductive Health
NFE	Non-Formal Education
NGO	Non-Governmental Organization
NHTC	National Health Training Center
NP®	Norplant Subdermal Implant
NSV	No-Scalpel Vasectomy
OJT	On the Job Training
ORS	Oral Rehydration Solution
PHO	Public Health Officer
PLP	Post Literacy Program
PNC	Post Natal Care
RH	Reproductive Health
RPLL	Reinforcing Post Level Literacy

S/HPSC	*Sub Health Post Support Committee*
SDK	Safe Delivery Kit
SLP	Self Learning Program
ST	Service Takers
STD/STI	Sexually Transmitted Diseases/Infections
TBA	Traditional Birth Attendant
TH	Traditional Healer
TT	Tetanus Toxoid
VDC	Village Development Committee
VDRL	Venereal Disease Research Laboratory
VHW	Village Health Worker

ADRA Nepal
Integrated Community Based Family Health Program Kavre
Final Project Report July 1997-June 2002

PART II

Kavre District

Intervention One: Family Planning Training

1. Target & Accomplishments

ADRA Nepal has been conducting family planning trainings to a wide range of health personnel through its Family Planning Training Center (FPTC) at Banepa. The FPTC of ADRA Nepal is a MoH recognized family planning training center at the national level and has contributed significantly to achieve USAID's strategic plan for Nepal (1995-2003) "the sector, (MoH) is in need of improved management, especially of key components of public health programs such as logistics, training, staffing, supervision, and integrated delivery systems". Clinical and non-clinical trainings in family planning methods such as minilaparotomy under local anesthesia (ML/LA), No-scalpel Vasectomy (NSV), Norplant® insertion/removal, Comprehensive Family Planning/Counseling (COFP/Counseling), Intra-uterine Contraceptive Device insertion/removal (IUCD), and Sexually Transmitted Diseases Case Management (STD/CM) are conducted on a regular basis. FP training adopts adult learning principles, encourages active participatory, student-centered, self-paced, and competency-based training methods based on the Nepal Medical Standard.

The general objective of Project Intervention One: Family Planning Training - was to train health personnel (doctors, nurses, and paramedics) engaged in providing family planning services, and thus to increase the availability of high-quality family planning services in the government and non-government sector throughout Nepal. FP training is one of the successful, visible, and impact-oriented project activities and through this activity ADRA Nepal has earned an excellent reputation and recognition from all quarters.

During the project period this objective was largely met. Numerically there was a 79% achievement (379 of 480 planned) (see Annex 1). More than 99% of participants successfully completed the competency-based knowledge and skill part of the trainings.

Looking at the figures, achievements have surpassed the expected numbers in ML/LA, Norplant® and IUCD training (Figure 1). Norplant® training has achieved more than other training programs because there was increased demand for this training. Client flow was also satisfactory. On the other hand clients accepting IUCD were very low to continue further training. The FPTC during the period of July 1997 to June 2002 conducted 71 batches of trainings (Table 1).

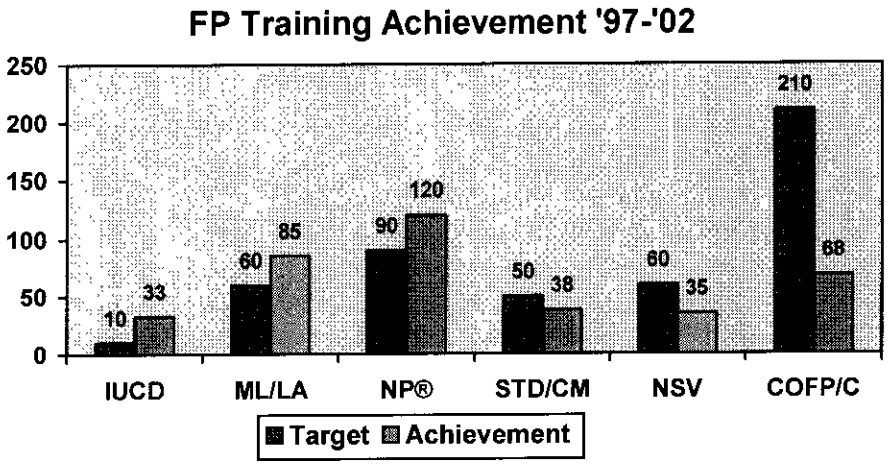


Figure 1. Distribution of FP training participants by FP training method

Training to government participants consisted of 26 batches. Norplant® training constituted the highest number of training batches, suggesting its wider popularity, followed by female sterilization.

Table 1. Distribution of training achievements by training batch

Training	Planned Expectation	Achievement
Norplant	15	25
IUCD	5	6
NSV	10	14
ML/LA	10	18
COFP/Counseling	30	5
STD/CM	5	3
TOTAL	*75*	*71*

Participants from all over the country benefited from ADRA Nepal's training program. Majority (61%) of participants were from central region (Figure 2).

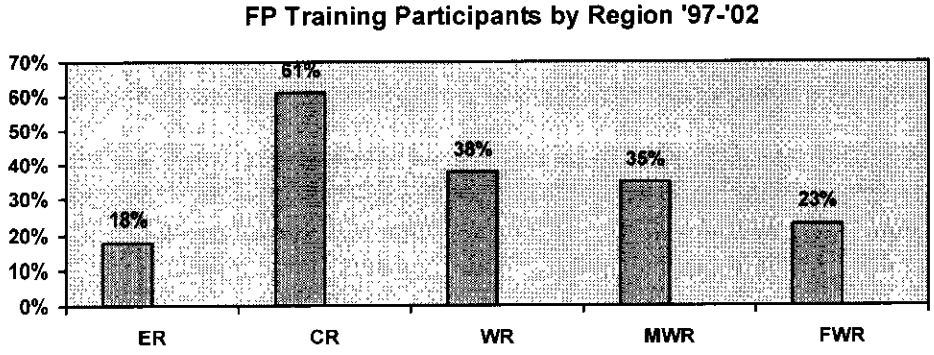


Figure 2. Distribution of FP participants by Region

Over the project period ADRA FPTC trained health personnel from both GO and I/NGO sector (Table 2). Nurses from I/NGOs comprised the majority.

Table 2. Distribution of trainees by origin of employment

Trainee	Government	I/NGO	Total
Doctor	64	21	85
Nurse	64	123	187
Paramedic	62	45	107
Total	**190**	**189**	**379**

100 ADRA Nepal staff also obtained different FP trainings during this project period. Three training follow-ups were carried out.

1.1 Success stories

- Contraceptive Technology Update session at the end of training was a much talked about part of the training for most participants. This part is very useful to the participants to update and refresh their knowledge in the field of Family Planning.
- ADRA Nepal FPTC successfully trained and released one pair of physician and nurse team at ninth day of scheduled seventeen day training (ML/LA). NHTC and other training institutes have taken this event as a reference of excellence in training.
- All of the trainees succeeded in obtaining certificate except one in ML/LA.
- During the training, observers from NHTC/JHPIEGO has visited the training site many times and appreciated the site and the proficient trainers.
- ADRA Nepal often took trainees in mobile clinics for their practicum part. This has generated significant enthusiasm to the trainees as this gave them the opportunity to work like situation of their own and appreciated very much.
- To retain trained trainers, which were recommended in the mid-term evaluation report also, ADRA management came up with a new scheme of providing incentives to the trainers.

1.2 Constraints and problems

- Lack of Norplant® supply for a year in August 2000 resulted in a slowing of NP® training.
- Training-follow up of ADRA FPTC graduates on a regular basis could not be carried out due to unfavorable political and security situations as well as time and human resource constraint during the peak 'seasonal' months when training and service delivery is at its peak.
- Lack of residential facility for the participants is an issue often pointed out by the participants. As recommended also in the mid-term evaluation report ADRA Nepal managed to acquire this facility just recently.
- As recommended in mid-term evaluation to increase participants from far-western region, nothing substantial could be done on this regard as this was not under the control ADRA Nepal because ADRA Nepal provides training to those selected by NHTC.
- We could not manage the separate library for FP training as recommended in mid-term evaluation. However, IEC materials and books for reference are well kept in a resource room.

2. Reasons for Deviations

- Target of COFP/Counseling was not met simply because NHTC changed its training strategy. COFP and Counselor Trainings, once separate, were then merged a couple of

years ago. Another reason is that national training centers like ADRA Nepal ceased to conduct this type of training as the Regional Health Training Center (RHTC) of MoH took over this responsibility.

- The reason for a lower number of STD/CM training is due to the fact that for the last two years, a University of Heidelberg Project responsible for carrying out this training, requested ADRA Nepal not to conduct any STD/CM trainings until they come up with a revised training curriculum. It interrupted the training and the target is under-achieved.
- The target established for NSV was highly ambitious and not feasible to accomplish.
- The accomplishment for NP®, ML/LA, and IUCD exceeded expectations. Based on the strength of ADRA FPTC, NHTC also supported by allotting more batches of training assignments in NP® and ML/LA. Regarding IUCD training, ADRA Nepal requested not to assign this training, as the client flow was very low. The previous trainings were also conducted in other training centers.

3. Report of Investigation

3.1 Excerpts from Mid-Term Evaluation

Most of the targeted family planning training has been conducted except training on vasectomy and COFP/counseling within 1999. The participants for training attended from 41 of 75 districts of the country. The competency-based training provided for all categories of health personnel is of high quality. With the production of competent graduates ADRA has contributed to expand qualitative FP services in the health facilities of government and non-governmental sectors.

Short-term impact: It is difficult to evaluate the impact of the program, which has a national target. However, on the basis of the quality maintained during the training it can be speculated that after completion of different FP courses by 255 medical personnel the availability of high quality FP services must have increased significantly in the governmental and non-governmental sectors. The follow up visits made by ADRA trainers also found that the trained persons satisfactorily implemented clinical procedures on Norplant ® and minilap and most of them expressed confidence in the skills they were performing. Apart from a few individuals most of the trained staff were providing the skills they have acquired.

3.2 Excerpts from Final Evaluation

It was observed that the objectives of the family planning training were largely met. The Family Planning Training program has tremendously increased the capability of health workers, community leaders and the people alike to take the initiative, and to make informed and timely decisions on family planning issues. The training carried out for the district level doctors, nurses and paramedics in family planning has been quite useful as CPR has increased in the program areas, and consumers are continuing with services.

The FP training program was found to be highly effective in meeting the project goal.

3.3 FP Training Follow Up - December 1999

Slight modification of the clinical skills was noted but they are of minor significance. Most of the staff expressed confidence in the skills they are performing.

Intervention Two: Maternal and Child Health

1. Targets and Achievements

This intervention has three components i.e. reproductive health, child health and women's literacy. The primary target population for RH is women of reproductive age (WRA) and the secondary target are men of reproductive age in the program area. The general objective is to empower couples of reproductive age to make appropriate decisions and develop positive health practices for reproductive health and provide high quality maternal and FP services which will empower overall health of the target population in the program area.

For child health, the target populations are infants and children, less than five years of age in the program areas and the general objective is to increase maternal knowledge and use of CDD, ARI, Immunization and nutritional health practices and increase accessibility of child health services in the program area. The following activities were implemented in Kavre to achieve the set objectives under the heading of field, training, FP/PHC and mobile clinics.

1.1. Field Activities (Annex 2)

- Conducted 26,085 monthly mothers group meetings in Kavre
- Conducted 490 health quiz contests among mothers group members in Kavre
- Conducted activities on National Condom Day, World AIDS Day, National Immunization Day and International Women Day each year
- Sponsored 51 street drama presentations in Kavre
- Conducted 66 urban health education sessions in Kavre

1.1.1. Mothers group meetings

The purpose of mothers group meetings is to increase health awareness through the health volunteers. The meeting focuses mainly on health education for the women and by the women. The objectives of the meeting are:

- To raise community health awareness among the women of reproductive age.
- To support FCHVs to conduct health and Family Planning activities in the community.
- To develop their responsibility towards families and community to apply good MCH and FP practices.
- To gain knowledge and understanding about health and Family Planning issues.
- To develop group dynamics for health promotion activities at the community level.
- To coordinate with villagers and health workers.

The Government of Nepal initiated the community based female health volunteers program in 1988/89 then it has been gradually expanded to all the districts of Nepal. ADRA Nepal has been implementing this program to strengthen the government's machinery. ADRA provided

refresher training and technical assistance to FCHVs. ADRA also guided Village Health Worker (VHWs) and Maternal and Child Health Worker (MCHWs) to monitor the activities of FCHVs and mothers groups. In ADRA's working area (46 VDCs), field representatives (FR) and family planning counselors (FC) also assisted FCHVs in conducting monthly mothers group meetings (MGM). ADRA with the help of VHWs and FRs identified the weaker mothers group and also reactivated them.

1.1.2. FCHV/TBA/TH Activities

In the beginning of the program, there were 654 FCHVs in ADRA's working area in Kavre. The number has decreased to 600 due to various reasons. They are responsible to conduct mothers group meetings and first aid treatment. They also provide one-on-one counseling and health education and refer to the health service sites. During the last five years, most of the mothers group meetings were found to be regular. More than 26,000 MGMs were held, out of which 86% (n=22,312) meetings were attended by more than 11 women.

Initially there were 485 TBAs in the program area. Now there are 493 TBAs in the program area. TBAs were expected to do antenatal and post-natal checkups and refer all the high-risk pregnancies to the nearest health service center. More importantly, they were expected to assist, perform clean deliveries, and give timely referrals to higher centers when necessary. During the last five years, 1,673 cases were referred by TBAs. About 1/3rd deliveries (6,246 of 18,368) were handled by trained TBAs (TBAs) in the program area. About 4,800 Safe Delivery Kits (SDKs) were distributed by TBAs. Similarly, TTBAs made 8,800 PNC visits and provided PNC services.

ADRA provided 3 days of basic health education training to 249 Traditional Healers in Kavre. Presently there are 217 Trained Traditional Healers (TTH) actively working in Kavre. They are playing a vital role in the community even when modern medical facilities are available. Many people prefer to have a consultation with local THs first in case of illness and then to health facility if advised by the TH. About 60,500 patients were treated by or consulted to by TH over the project period, which translates to 56 patients per TH per year. TTHs referred 8,259 ARI cases and 2,977 diarrhea cases.

1.1.3. Health quiz contests

Health quiz contests are considered an effective method of disseminating health knowledge to WRAs in the community. Health quizzes were successful in encouraging mothers attending MGMs. During the last five years, 490-health quiz contest were held in Kavre. On average 22 mothers participated in each event. Altogether about 10,780 women participated.

1.1.4. National/International Days Celebration/Street Drama

Teej Festival, Condom Day, AIDS Day, Women's Day and National Immunization Days were celebrated each year in coordination with local municipality, DHO, Red Cross and other partners in the district. Health song competitions, rallies, and exhibitions were organized during these days. The objective of these activities was to create mass health awareness through these events.

A local drama team was hired to perform drama shows in the program area. The drama script was based on the key objectives of project interventions such as safe motherhood, diarrhea,

ARI, FP and HIV/AIDS. The community found the awareness activity through the drama exciting. During the last five-year period, 51 events of drama were performed in different VDCs of Kavre and on average 300 community people benefited from each.

1.1.5. Urban Health Education

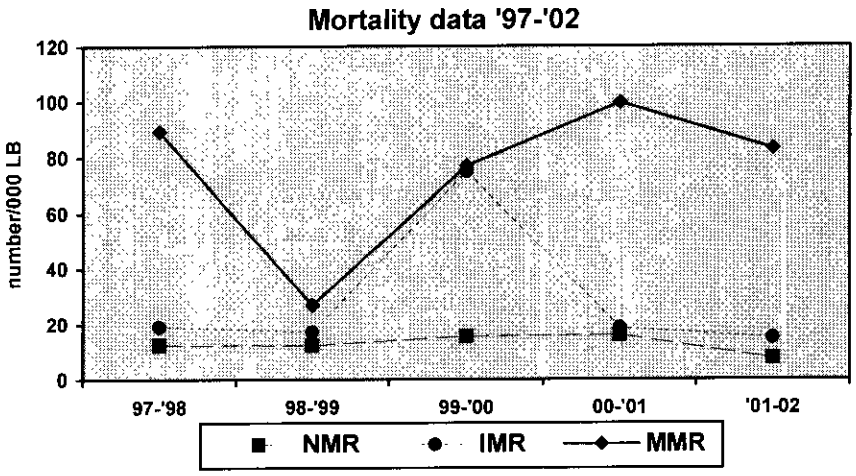
With the objective to strengthen the activities of FCHVs and MGMs in urban areas (Banepa & Dhulikhel), urban health education programs targeting WRAs including males and females and adolescents started in 2000. ADRA FR leads the program in monthly basis in two wards each in Banepa & Dhulikhel. Altogether 66 health education sessions were held with an average of 22 participants attending each session. The health education sessions are tailor made and based on felt needs of the groups. Some of the topics covered were adolescent/sexuality health issues such as physical, emotional and behavior changes during the adolescent, prevention of premarital sexual activities, STI/HIV/AIDS prevention, teen age marriage, pregnancy and unsafe abortion.

1.1.6. Impact of the Program

The mother's group meetings have tremendous positive results in the community. The meeting has helped to increase FP acceptor. ADRA's program in Kavre has attained a CPR of 61%. Annually, more than 30 FCHVs/TBAs bring or refer potential clients for FP in ADRA/PHC clinic. The participation of mothers in the MGMs has increased. Increased ANC check ups by the trained health personal (84% by health personal and 30% by TTBAs) has also increased. Group efforts are seen in the community to organize sanitation campaigns. Majority of pregnant women are aware about the use of SDKs and assistance of TBA.

MGMs have been a very useful forum for dissemination of basic health care service information as well as an opportunity for sharing and learning in the community level. Some MGs in the program area are actively conducting income generation and fundraising activities. They are coordinating with District Agriculture Office, Women's Development Office, NGOs and INGOs.

These efforts have helped to decreased infant and child mortality in the community (IMR 15/1000 live birth) in ADRA program area. The figure (3) below shows the mortality trend in the program area.



Source: Field Registration Data

Figure 3. Mortality trend in Kavre program area by years

It is very hard to determine why this fluctuation happens every year. There are so many reasons noted for maternal mortality i.e. prolonged labor, retained placenta, P/V bleeding and carelessness in seeking timely medical treatment etc. The common reasons for child deaths were diarrhea, dysentery, malnutrition, high fever, cold, pneumonia, and others.

1.1.7. Lessons Learned

- The FCHVs are good health educators for MGs in the community.
- Women improved their health by participating in MGMs.
- MG is appropriate group for two way communication
- In the occasion of religious function, members of MGs play a very important and effective role to gather and co-ordinate activities like health education.
- Small amount of money collected every month helps for small income generating activities. This has helped strengthen the mothers' group unity. Having some loans to develop their agriculture and commercial business benefits some mothers.
- Social status of women has increased by participating in such meetings.
- Women are confident to speak frankly about their problems in the meeting.
- Mothers group members are willing to be educated and request literacy classes.

1.2 Field Training Activities (Annex 3)

The objective of training activities were to strengthen MoH's district health service delivery by providing training to the health service providers, strengthen community health program by providing training to health volunteers and to update and enhance the health knowledge, skills and practice of health workers and volunteers.

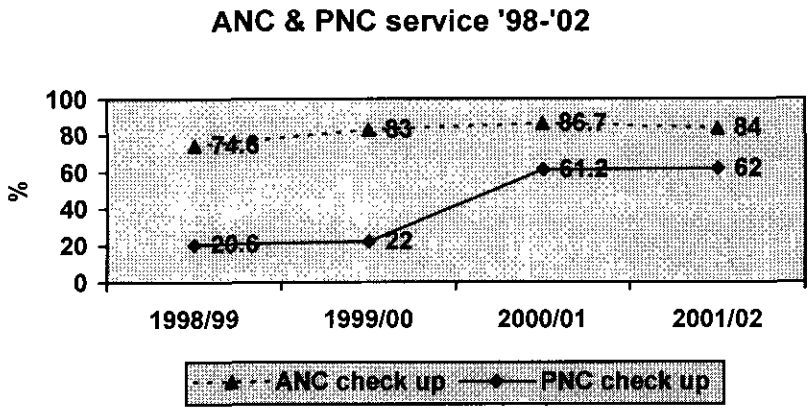
To fulfill the above-mentioned objectives the following training activities were implemented in Kavre:

- Refresher training provided to 156 HP/SHP staff in Kavre

- Review meeting of 137 FCHVs conducted twice each year in Kavre
- Supervisory Meeting of 432 TTBAs conducted 2 x year except in fifth year in Kavre
- Refresher training to 229 TTHs conducted each year in Kavre
- Refresher training to 56 FP counselors conducted each year
- Sponsored FCHV/TBA/TH joint meeting every four months in Kavre

1.2.1. Impacts of the Training Program

Training program has greatly benefited the S/HP staff particularly through capacity building. There has been increases in the knowledge and management capacity of S/HP in-charge, VHWs and MCHWs who were newly transferred and recruited for Kavre district. For most of the newly placed MCHWs in the health facilities, the training helped them to refresh their knowledge and enrich their skills related to the job. Similarly, periodic review meetings of health volunteers added energy to boost their commitment and continue to work better. Drop out FCHVs and TBAs were fulfilled and trained in coordination with DHO. FCHVs are regularly conducting MGMs and MG members have shown their interest in participating in literacy classes. Community houses for MG meetings and literacy classes (VDCs of Sankhu, Jyamdi, Chaubash, Hokse) were constructed by MGs in their own initiative. TBAs, after their supervisory meeting, were encouraged and motivated to provide ANC service and timely referral of high-risk pregnancy cases. Numbers of FP method users has increased. Similarly there has been increased use of SDKs in deliveries handled by TTBAs.



Source: Field Registration Data

Figure 4. ANC and PNC check up by Years

TBA refresher training focused more on ANC and PNC check up. In some VDCs, TBAs were awarded for their good performance. In some places new TBAs were recruited to replace inactive ones and they were very energetic and are working well.

There is a high increase in PNC check ups (Figure 4). This is due to the change in reporting system as well as an increase in PNC visits by TTBAs and FP counselors. Earlier all women who delivered in the hospital were not recorded.

1.3 Urban Health Education

This small activity was stated as a pilot test in 2000 with objectives to strengthen the activities of FCHVs and MGMs in urban areas (2 wards each in Banepa and Dhulikhel), targeting WRA including male and female adolescents. Monthly health education sessions were held with an average of 22 participants attending per class. Health education sessions conducted on the felt needs of the groups. Varieties of methods were used and most popular and preferred one is video shows.

1.4 Community Health Finance Scheme - Saradabatase

The process of establishment, restructuring, strengthening of ward health fund raising by mothers in MGMs, to provide loan assistance (without interest) to the families of this VDC for emergencies like delivery and other health related care was facilitated by ADRA Nepal. Nine health savings groups (one in each ward - called ward health funds) were started primarily for health, however the money was lent for other business as well, as the amount grew over time. The project was implemented as a pilot test and was quite successful. The model will be replicated in other VDCs. The project restructured the saving and credits groups already existing and operating in the communities.

1.5 Women's Literacy Program (Annex 4-5)

- Site/participants and facilitator selection
- Initial training, refresher training and implementation workshop
- Evaluation/examination; Supervision/monitoring/follow-up
- Regular meeting/reporting

Due to the high percentage of female illiteracy in the district, ADRA introduced female literacy classes to make MWRA literate and make them more aware about basic health messages. The target population obviously are women of reproductive age (15-49) with no or low literacy skills in the program area. Female literacy has been considered key in empowering women of reproductive age to make positive decisions regarding FP/MCH. The relation between literacy and improved family health has been well-proven elsewhere.

The objective of the program was to increase the appropriate health knowledge and practice of WRA. In order to achieve the goal of reducing fertility and improving the health status of women and children, ADRA Nepal has been implementing female literacy classes in the project area.

The women's literacy program has three separate levels such as basic, post and self-learning. The basic level of the literacy program is offered to illiterate adult women for seven months including simple literacy components such as reading, writing and numeric. The post level literacy program is offered to neo-literate adult women for four months and includes higher course content of literacy and continued functional health messages. The self-learning literacy program is offered to women who are satisfactorily literate and wants to pursue more for a further six months on a fortnight contact session schedule.

1.5.1. Basic Literacy Level (Figure 5)

3,674 (117%) of 3,125 planned WRA have completed the basic literacy course during this project period.

Objective (a): Upon the completion of the BLP course 80% of the participants will be able to recognize the signs and symptoms of severe ARI,

Achievement: 65% of the literacy participants were able to recognize the signs and symptoms of severe ARI in Kavre district. Objective not met during the completion of ICBFHP.

Objective (b): Upon completion of the BLP course, 80% of participants will have knowledge of appropriate management techniques for non-severe diarrhea.

Achievement: During ICBFHP 1997-2002 84.4% of participants found able to manage appropriately of the non-severe diarrhea.

Objective (c): Upon completion of the BLP course, 90% of the participants will have received at least 2 TT doses (documented in immunization cards).

Achievement: Upon the completion of BLL 71% participants received at least 2 TT doses

Objective (d): Upon the completion of the BLP course, 90% of the participants will pass the basic literacy examination.

Achievement: Upon completion of BLL 92% participants passed the basis literacy examination.

Objective: (e): Upon the completion of BLL course 80% of the participants will pass the health knowledge assessment.

Achievement: 94.4% literacy participants passed the health knowledge assessment as per the required objectives in Kavre district.

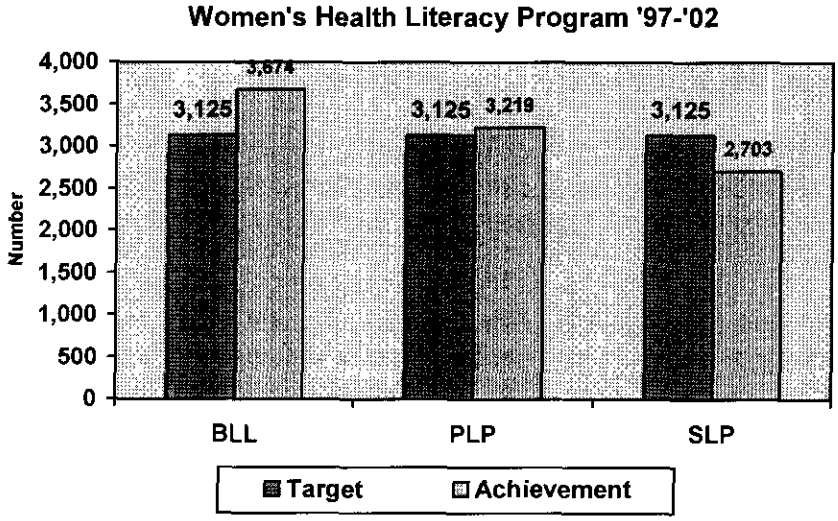


Figure 5. Target vs Achievement of Literacy participants by literacy level

1.5.2. Post Literacy Level

Planned achievement of post literacy exceeded the planned expectation. 3,219 (103%) of 3,125 WRAs successfully completed post literacy level in Kavre

Objective (a): Upon the completion of PLP course, 90% of the participants will be able to recognize the signs and symptoms of pneumonia.

Achievement: 81% participant were able to recognize the signs and symptoms of pneumonia
Objective (b): Upon the completion of the PLP course, 90% of the participants will have knowledge of appropriate management techniques for non-severe diarrhea.
Achievement: 82.5% of participants had knowledge of appropriate management of non-severe diarrhea in Kavre district.
Objective (c): Upon the completion of the PLP course, 40% of the eligible participants will become users of the family planning methods.
Achievement: 65% literacy participants used a FP method (permanent or temporary).
Objective (d): Upon completion of the PLP course, 90% of the participants will pass the second level literacy examination.
Achievement: 90% PLP participants passed the final examination in Kavre district.
Objective (e): Upon completion of the PLP course, 90% of the participants will pass the health, environment and forestry knowledge.
Achievement: 97.5% literacy participants passed the health, environment and forestry knowledge in PLP final examination in Kavre

1.5.3. Self Learning Level

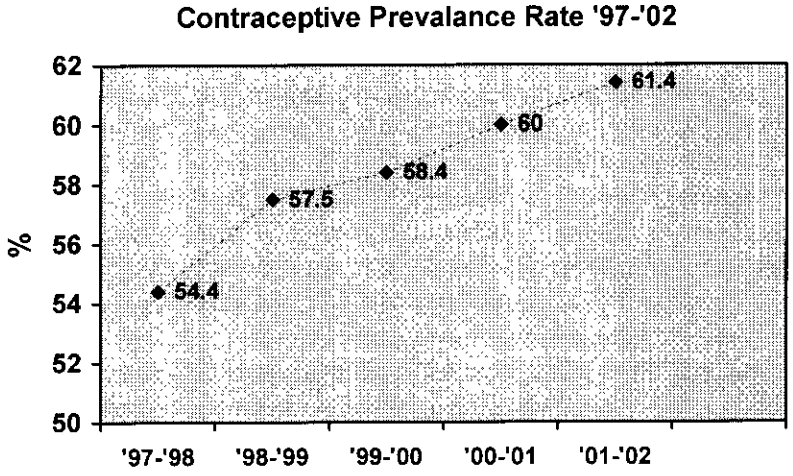
Planned achievement was less than expectation. 2,703 (86%) of 3,125 WRAs mothers completed the self-learning literacy level in Kavre

Objective (a): Upon completion of the SLP course, 90% of the participants will pass the third level literacy examination.
Achievement: 97% SLP participants passed the final examination in Kavre district.
Objective (b): Upon completion of the SLP course, 90% of the participants will pass the health, environment and forestry knowledge assessment.
Achievement: 97.5% literacy participants passed the health, environment and forestry knowledge in PLP final examination in Kavre

1.5.4. Impacts of the Literacy Program

- Sanitation and environment knowledge of literacy class participants have improved. SLP level participants cleaned community drinking water sources, constructed garbage disposal pits, and toilets.
- Health knowledge of participants (third level) has been converted into practice. Number of contraceptive method users increased.
- Number of ANC check ups increased at S/HP as S/HP staff provided information about the services provided through the local health facilities
- Health knowledge among literacy participants has improved significantly. 96% could correctly define diarrhea. Similarly, 79% could tell the proper management of non-severe diarrhea. 77% could tell the sources of Vitamin A rich food.
- Perceived improvement in the quality of life of mothers and children
- There are some remarkable changes in the health behavior of the individual participants. Some stopped smoking after they joined the class. There have been visible improvements in the personal hygiene of literacy participants.
- The CPR is increasing every year in Kavre program area. The CPR for Kavre program area (61.4%) is significantly higher then the district average of 48% and national average of 39% (Figure 6). It could be due to the raised awareness through health education through MGMs, literacy classes, S/HPSCs, easily available and accessible

methods of FP through mobile clinics, and proper counseling at field level as well as in the clinic.



Source: Annual Field Registration Data

Figure 6. Contraceptive Prevalence Rate by Years

1.5.5. Lessons Learned

- The time gap between transitions of class levels should be short to sustain the learned knowledge and skills.
- It was learnt that unlike the usual evening or nighttime for adult literacy for women, morning or afternoon time is not preferable but acceptable for conducting classes

1.6 FP/PHC Clinic Kavre (Annex 6-7)

Approximately 133,400 client visits to services delivery point were made during project period. There is 25% increase in the client flow in the clinic suggesting increasing coverage of FP/MCH services from the clinic. Service delivery visits increased from 23,017 in first year to 28,816 in fifth year. Highest percentage of clients came for FP related services followed by ANC check ups (Table 3). Geographically, about half of the clientele came from rural areas of the project.

Table 3. Frequency distribution of clients/patients by service delivery types

Services	Total	Percentage
ANC	30,614	**22%**
Immunization ANC+Child)	16,909	**13%**
Under Five	19,596	**15%**
STD/Gynae	10,112	**8%**
FP Method related	43,431	**32%**
Others	12,774	**10%**

Women and children comprise 93% of total service delivery justifying the overall goal of the program - 'to reduce fertility rates and improve the overall health of women and children in the program areas'.

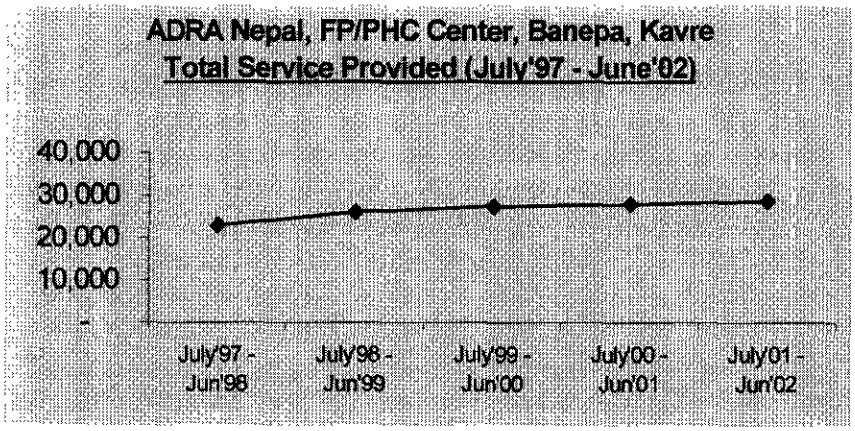


Figure 7. Distribution of Service visits at FP/PHC Kavre by year

1.6.1. ANC Services

There is significant (40%) increase in the number of pregnant women visiting the clinic during project period. About 66% (20,178 of 30,614 pregnant women time) pregnant women visits were repeat visits (≥ 2 visits) suggesting high return rate and satisfaction from the service. Since year 4 of the project (as per government's Safe Motherhood Program protocol) ANC visits 4 or more during a single pregnancy were also reported. In year 4 about 21% and in year 5 about 39% of repeat visitors have had >4 visits respectively (Table 4). Interestingly about 54% of the ANC visits were from rural area. In year 5, about 21% of total ANC visits were below the age of 20 years (adolescent pregnancy). About 13% of total ANC visits completed TT 2 shots. It is assumed that the majority must have taken their second dose in their respective VDCs.

Table 4. Distribution of ANC visit by age.

During 5th Year	Number of Cases		Total
Age	New	Old	
< 20 years	459	999	1,458
> 20 years	1,829	3,759	5,624
Total	**2,288**	**4,794**	**7,082**

1.6.2. Immunization services

Children immunization: There was a 257% increase in child immunizations. Number of child immunization visits for different antigens increased from 980 in year 1 to 3,501 in year 5. Almost 2/3rd of the beneficiaries are female babies. About 67% are from urban area. 33% completed DPT III +OPV III shots while 23% receive measles immunization.

ANC Immunizations: 6,580 women of reproductive age (WRA) received immunization against tetanus. Among them 388 were non pregnant. More than half of pregnant women receiving TT shots have had two or more than two shots of TT. 53% of women came from rural area.

1.6.3. Under Five Services

Under five service activity has been slightly decreased over the years. A total of 19,596 children visits were reported during project period. More than 2/3rd of them came from urban area. Children suffering form CDD and ARI related illness were 3% and 5% respectively. ARI cases are more in winter season. Almost 20% of growth-monitored children had different degrees of malnutrition.

1.6.4. STIs / Gynae

More then 2/3rd of 1,749 STIs cases came from rural area. During the project period there has been 205% increase in the number of women seeking advice for women-related problems and almost 60% of the women came from rural areas.

1.6.5. Family Planning services

About 10,000 men and women accepted new contraceptive methods during the project period. About 20% of new acceptors are males. Almost 2/3rd of all new acceptors are spacers. 2,105 are new female limiters (Figure 8). Depo being the most popular spacing method followed by NP®. Among the limiters 3 in 4 cases are females accepting tubal ligation. Over the last 2 years vasectomies outnumbered minilaparotomy. About 10% of new acceptors in limiting method came from out side the project area suggesting increased popularity of FP/PHC clinic. The number of IUCD acceptors did increase over the years. Majority of 1,700 NP® removals have had their implant removed due to the completion of 5 years. However, NP® removals decreased from last year as the effectiveness period extended 5yrs to 7yrs.

The project successfully collected 86,660 CYPs against the 5-year CYP target of 80,000 for Kavre. The achievement rate is 108%. Eligible couples used about 51,000 condoms for dual protection.

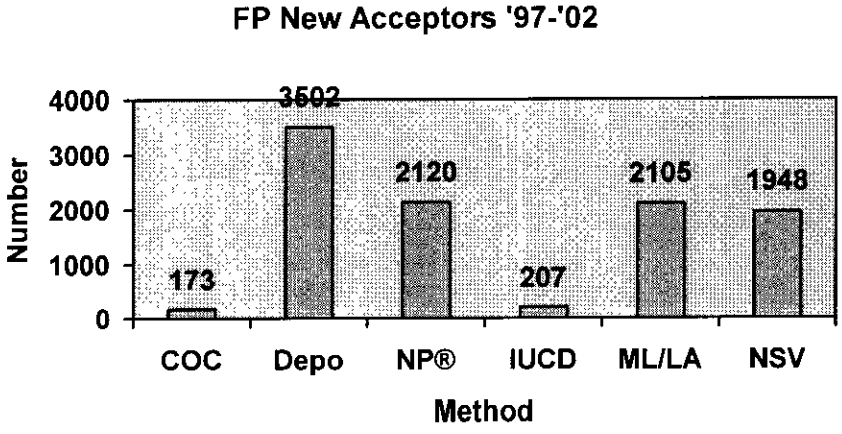


Figure 8. Distribution of New FP Acceptors by Method

1.6.6. Other Activities:

Nine doctors, 9 CMAs, 18 ANMs, 4 CHWs successfully completed their pre-service training assignments on FP/MCH at ADRA Nepal FP/PHC over the project period. Since last year MBBS 1st year students from Kathmandu University Medical School are visiting our FP/PHC clinic for clinical observation sessions. All these pre-service and observation trainings in ADRA Nepal clinic suggest increased excellence of service and its recognition by the teaching academic institutions.

1.6.7. Lessons Learned

Quality services do not come easily and take time with continuous improvements from supervisions and monitoring. FP/PHC has been always getting the best out of its staff, which has resulted in a good reputation of its service in Kavre district.

1.6.8. Successes

- Continuous increase in patient/clients visits during 5 years indicates successful completion FP/PHC project and is only due to constant quality service, increased popularity and good reputation of the clinic.
- Increase in NSV clients during last 2 years shows the increased male involvement.
- Not a single month goes without sterilization showing that the old concept "surgery in summer leads to infection" is changing gradually. Year-round sterilization services are available.

1.7 Mobile Clinic Services (Annex 8)

About 82% (383 of 470) of mobile visits were made over the project period in Kavre. 17,782 services were delivered. Most of the beneficiaries from these outreach mobile visits were women/children, underserved, and hard to reach groups in the community. The highest number of mobile visits (93) was made in year 4 of the project. The fifth year of the project saw less number of visits and hence lower number of service delivery. Due to worsening security situations, the mobile clinic program was suspended from November 2001. Majority of service seekers came for FP related services followed by ANC check ups (Table 5).

Table 5. Distribution of clients/patients by service delivery.

Services	Number (17,782)	Percentage (100%)
ANC	5,068	29%
Under Five	1,045	6%
STI/Gynae	1,446	8%
FP Method related	6,805	38%
Others	3,418	19%

1.7.1. Family Planning

A total of 5,600 CYPs were collected from 6,085 FP related cases from mobile visits. Among 1,522 new acceptors, Norplant® was most popular FP method followed by Depo. The demand for Norplant had been always high especially among the Tamang ethnic women.

1.7.2 Antenatal checkups & Under Fives

About 5,000 pregnant women visited ADRA run mobile clinics of which about 2/3rd were repeat visitors (> 2 visits) suggesting popularity of our mobile clinics for quality service. Of the 1,045 under five cases 182 were CDD and 242 were ARI cases.

1.7.3. STI/Gynae

Out of the total 1,446 STI/Gynae cases 210 were clinically diagnosed STIs. Twenty women attended mobile clinic with fertility problem. Among the Gynae cases uterine prolapse is one of the common health problem still faced by women in rural Nepal.

1.7.4. Successes

- Mahadevsthan has the highest prenatal visit records. Pregnant women twice a month came to the site for their ANC check up simply because "good" doctors and nurses from ADRA examine them satisfactorily.
- Women in Dolalghat came to the site walking at least for 4 hours from their houses just for a Depo shot simply because they "believe" and trust on the Depo given by ADRA Nepal.

1.8 Laboratory services

1.8.1. Central lab (Annex 9)

There has been increased activity in the ADRA laboratory. The number of cases and tests performed increased by 17% and 29% respectively, which clearly shows the cost effectiveness, reliability, quality and quick service of our lab. Average case flow increased from 433 to 507 per month while number of tests increased from 1,161 to 1,495. Majority (74%) of the cases were females (Figure 9). Tests related to urine constituted the highest (29%) tests performed followed by hematology.

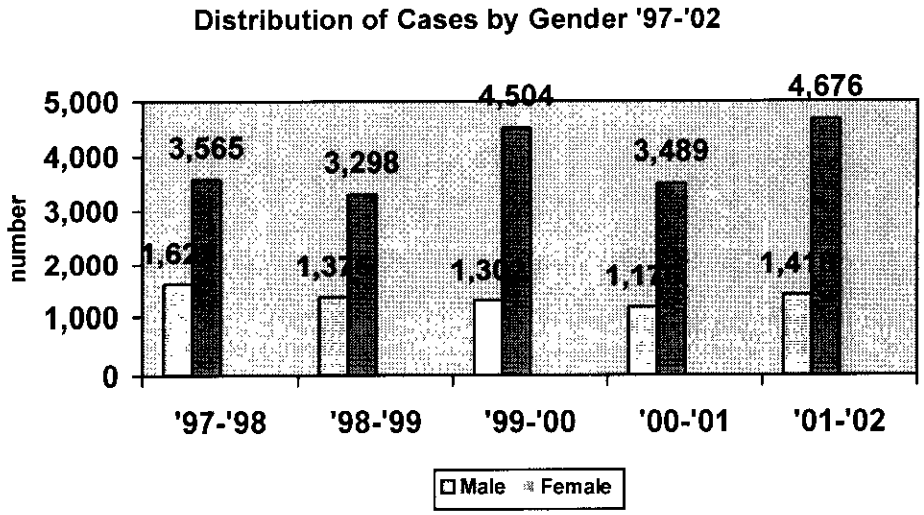


Figure 9. Distribution of Lab cases by gender

About 36% (1,749 of 4,898) pregnant women were found to be anemic (Hb < 11gm/dl), 37% had positive yield for worm infestation, and 1% had reactive VDRL test result (Table 6). ADRA lab detected 6 HIV and 8 HVB positive cases over the project period.

Table 6. Distribution of significant laboratory results among ANC cases '97-'02

Tests	Significant Value	Total	Significant	Percentage
Hemoglobin	≤11 g/dl	4,898	1,749	36%
Blood Group	Rh Negative	4,743	137	3%
VDRL	Reactive	4,838	31	1%
Stool RE/ME	Worm Infestation	3,343	1,244	37%
Stool RE/ME	Protozoal Infection	3,343	199	6%
Total		**21,165**	**3,360**	**16%**

1.8.2. Other activities

- 12 lab assistant (students) successfully completed their 3 months OJT (male:female 1:1).
- 10 lab assistants did volunteer work.
- Community health lab volunteers training (2 weeks) provided to 9 persons from different mobile clinic sites.
- Established new laboratory in Kalikasthan, Rasuwa.

1.8.3. Successes

- Some of the ADRA trained community health lab volunteers are regularly providing basic lab services to their respective community.
- In last few years ADRA's laboratory has been recognized as a reliable lab test center in Banepa and a referral confirmatory center for lab tests in Kavre district.

1.9 Mobile Lab

About 3,188 lab investigations were performed from 1,373 cases. Urine analysis was the most frequently performed test followed by simple hematology tests. Pregnant women benefited most. Clients in Mahadevsthan mobile clinic site sought most laboratory tests.

1.10 Family Planning camps

868 (533 tubal ligation and 335 vasectomies) sterilizations were carried out from 30 mobile family planning camps in Kavre district. ADRA contributes the bulk of the DHO targets on FP camps.

1. Reasons for Deviations

- 156 S/HP staff (VHW, MCHW, AHW/ANM, and HA/Staff Nurse) received refresher training out of 250 (50 persons every year) in plan. The reason of low performance may be the lack of S/HP staffs and also over targeted at the out set. We have covered 46 VDCs only but targeted to train 50/year. This is was not practical.

- 2 more counselors were mobilized in urban areas - the reason is dense population and geographic area covered.

- Initially one quiz contest was planned for 3 wards but in a staff meeting based on the popularity and success of the program it was decided to conduct quiz contest in each ward therefore the achievement became more than the target.

- One more street drama was shown by drama group free of cost upon request.

- The achievement of BLL and RPLL is more than the target. The reason cited is that in the beginning the drop out rate was very high (around 19%), then the target was set considering the 10% drop out but in the subsequent years drop out rate decreased to a minimum (less than 1%). The achievement of third level literacy is less than the targeted number. This is because of the late start of the program (only in 2000/01) due to budgetary constraints.

- Mobile Clinic visits: Accomplishment of mobile clinic visits was short by 18% (87 visits). Some of the reasons for the short fall in numbers are-difficult access due to unmotorable roads especially in rainy season, frequent 'Nepal Bandhs', and early cessation of mobile visits due to worsening security.

3. Report of Investigation

3.1 Excerpts from Mid Term Evaluation

FP Counselors: The presence and availability of counselor to the community has been greatly appreciated by FCHVs. Good recording and reporting system has been established since the counselor services started.

Community health volunteers: The interviews and focus group discussion with mothers have indicated that tendency of the pregnant women to seek ANC check up is increased. The information shows the positive impact of the FCHVs, counselors and TBAs' efforts in educating pregnant women about the importance of antenatal care. It was found that the women of literacy classes did not know about the immunization before joining the classes but now they had learnt the purpose of the vaccine from their lessons. The discussion revealed women in that areas are very conscious about their health. This is due to the good health education and motivation provided by the counselors, FCHVs, and TBAs in the ADRA.s working areas. Due to the active involvement of FCHVs in fieldwork, most of the mothers have developed positive attitudes towards the utilization of maternity services.

WHLP: Women's literacy classes had been an effective vehicle to disseminate reproductive health information among the womenfolk. ADRA has successfully developed the level wise scheme of the literacy program, such as basic, middle and self-learning levels, which is lacking even in the government health service program. ADRA is the only organization, which is implementing self- learning literacy program and also adopting the World Education HEAL materials. This effort is commendable and stands as an example of the uses of locally developed materials.

FP/PHC: The health service provided in Banepa PHC Center is found highly qualitative in comparison to Rasuwa, because in Banepa, qualified physicians and nurses with higher degrees and training manage the clinic.

Mobile Clinic: The strength of the static and mobile clinics is that they have increased the accessibility and availability of FP/MCH services in both the districts. The mobile clinic services organized by ADRA are supporting in making health services accessible and available in remote parts of both the program districts. The formation and mobilization of mobile clinic support committees are genuine tasks ensuring public participation and sustainability of the primary health care at the grassroots. Mobile family planning services had provided the opportunity for those who want to utilize the permanent and temporary family planning services, such as Norplant, Minilap, and Vasectomy.

3.2 Excerpts from Final Evaluation

MCH: Integrated working strategies: ADRA Nepal has introduced an integrated type of working strategy in the program areas. All reproductive and child health activities were introduced in the community. VDC Level Counselors (Kavre): The fact that all VDCs have had a FP counselor has given more of a focus on RH and Child Health. This has had an impact at monthly MGMs and other areas.

Community Health Volunteers: As a result of training of TBA, FP counsellors, MGs and organizing basic training for newly selected FCHVs the total human resource contributing to this cause tremendously increased family planning acceptors.

WHLP: Implementation of self-learning literacy program and also adopting the World Education HEAL materials. This effort is commendable and stands as an example of the use of locally developed materials. The focus of the literacy/NFE program has been on women of reproductive age, and this is a direct attempt by ADRA to impact reproductive and family planning health behaviors with that target group. Both the final evaluation team members, as well as partners from the district felt that the ADRA literacy/NFE programs were more successful and better run than those supported by the Ministry of Education and the NGOs coordination committee in the district.

FP/PHC: The ANC services were deemed very effective – if there was any complication seen they referred promptly to hospital. With ANC at Banepa they have a package arrangement. It seems that there is a high demand for ANC services in the Banepa clinic as mothers told how they liked to be benefited by coming to Banepa for a thorough check (including blood tests), and then are also able to do their other business at Banepa at the same time.

Mobile: Community leaders were very appreciative of both these service (Mobile, FP, dental, and Gynae camps).

3.3 Field Registration Data Analysis (Annex 10)

A Field Registration system was established by the project to collect/information from the field related to project intervention by mobilizing the FP counselors (semi paid volunteers at the VDC level). Every year the data was analyzed and the results were used for project monitoring and planning. The information about maternal care, fertility, mortality, and FP service acceptors in ADRA working areas helped to identify the weak program areas and the

community. Program activity was focused in those areas in the following years. The compiled information was also disseminated back to the community and district level every year. Analysis of the past five year's field registration data clearly shows remarkable improvements in most of the health behavior (Table 7). The following tables show a detail distribution.

Table 7. Major Health Indicators of Kavre Program area by Years

INDICATORS	97/98	98/99	99/00	00/01	01/02
Contraceptive Prevalence Rate (CPR)	54.4	57.5	58.8	59.9	61.4
Total Fertility Rate (TFR) Per MWRA	2.6	2.6	2.6	2.6	2.6
General Fertility Rate (GFR) Per thousand MWRA	79.0	80.0	79.0	76.0	67.6
Neonatal Mortality Rate (NMR) Per thousand live birth	12.5	12.3	15.6	16.0	7.5
Infant Mortality Rate (IMR) Per thousand live birth	19.0	17.1	20.0	18.7	14.9
Maternal Mortality Rate (MMR) Per thousand live birth	89.3	26.8	76.8	99.7	82.9

Source: Field registration data –ADRA Nepal

When compared with the whole district and nationwide data a significant difference in favor of the program areas can be seen. According to DoHS Annual Report, 2056/57 the CPR was 48% and 34% respectively for Kavre and the nation respectively. Similarly, the percentage of ANC check ups by TBAs and Health personnel (HP) was 43% and 30% respectively for Kavre and the Nation. The improvements of these health indicators are thought to be the impact of the ICBFHP.

3.4 Study on Trained Traditional Healers

MERS conducted a 'Study on Trained Traditional Healers (TTHs)'. The immediate objective of the research was "to review the TH program in order to strengthen the TH program and to formulate an appropriate referral system that will help realize the full utility of health facilities". The specific objectives were as follows:

- To describe the general characteristics of THs and patients including age, ethnicity, sex, family type, education, and occupation
- To assess the impact of TH training
- To assess the service providing behaviors of THs
- To assess the health seeking behaviors of patients
- To describe the process of TH card development, training, distribution, collection, and use
- To assess the gap between the knowledge and practice of trained THs regarding the use of the TH card
- To assess the TH referral system through patient interviews

Both qualitative and quantitative methods were used for information/data collection; i.e., focus group discussion (FGD) guidelines for trained traditional healers (TTHs) and ADRA staff, and the structured questionnaires for service takers (STs); i.e., patients/clients who sought treatment from a TTH within the last two weeks. Reporting forms were also prepared; i.e., a Demographic Information Collection Form, a Tracking Sheet, and TH Card Review forms. Eleven FGDs were conducted during this study and 119 STs were interviewed.

The study shows that the THs were the 'first line' contacts for medical attention in the community. People took the patients first to a TH because they mentally believe in blowing (phukphak-blowing air) and also because the THs are easily accessible. This was corroborated

by the ST responses, because almost 85% reported that they would seek future treatment from a TH for their children. A total of 97% reported they would seek future treatment from the TH for themselves and for their family members, and that represented a strong belief in THs within the community as well.

The TH training did not try to do away with home therapies, but emphasized that if they did not work or if harmful symptoms were noted then immediate referral to the HP should be made. Pneumonia, for example, should be referred immediately; diarrhea, malnutrition, fever and other diseases can be treated traditionally but should be referred if the treatments prove ineffective.

It was found that most of the patients visited a TTH for many ailments from diarrhea, dysentery, to chase away bad spirits (Figure 10). Regarding management of these cases, most of the TTHs reported first blowing once or twice and then referring to a HF if the patient didn't recover.

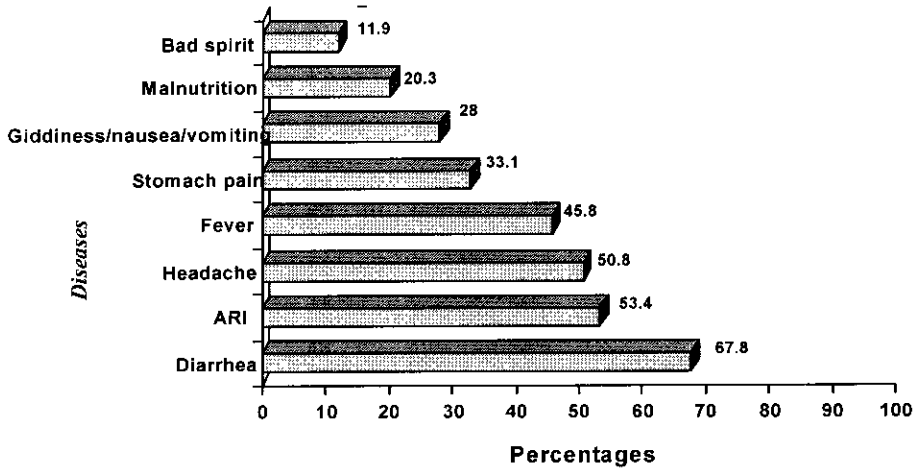


Figure 10. Distribution of Patients seeking treatment from TTHs

The answers given by TTHs and STs regarding health services were quite consistent. Asked what they do with pneumonia cases, almost all the THs reported they refer pneumonia cases immediately to the HF. Asked the same question, STs' top two responses were 'blowing' and 'refer to HF.'

Almost 89% of STs reported, they first sought treatment from the traditional healer, indicating a strong belief in the TH. All the STs reported TH's blowing once and then referring. Of those who were not referred (n=32), almost 70% reported they recovered after the TH's treatment. A total of 97% of the STs were satisfied with the TH's services regarding how long it took to reach him, his treatment methods and behavior, the facilities, and referral (Table 8). Of those who were not satisfied, gave 'only blowing' as the reason.

Table 8. Client Satisfaction with the TH Service, Kavre

Satisfaction with the TH service	Number	Percent
Very satisfied	13.0	10.9
Satisfied	85.0	71.4
Fair	17.0	14.3
Unsatisfied	4.0	3.4
Total	**119**	**100.0**

Some of the suggestions that were made to improve TH activities were; TH provide more general medicine, TH should encourage and provide training on hygiene, sanitation, and the importance of modern therapies to the local people, HP should keep good medicine, training should be conducted nearer to the THs, and that training should be given to the as yet untrained THs.

The training was not intended to discourage THs from performing their traditional practices, but to teach them when the patients need referral to a HF. This would help to minimize delays in receiving appropriate treatment. The study showed that overall referral has improved by training THs. This study suggests that although the TH training was effective, there is some room for further improvement when the program is implemented and expanded in the future.

3.5 Women's Literacy Program Evaluation

MERS also conducted the 'women's literacy program evaluation' at least 3 times (1 BLL and 2 PLP). The objective behind this was to strengthen the literacy program in terms of quality of education and health message. Pre and post surveys of women in literacy classes have been conducted in Kavre and Rasuwa districts to assess the knowledge of the participants. Post literacy evaluation study 1999/2000 in Kavre showed:

- 88% of literacy participants had acceptable overall performance in the literacy evaluation. Drop out rate was 10%
- 69% of women enrolled were in the age group of 18-35 years, while 63% were married, criteria set by the project (target group)
- 47% of participants were of Tamang ethnic group suggesting satisfactory coverage of the 'needy' group

3.6 Evaluation

Mid-term and Final Evaluation Surveys (Rapid KPC Survey)

The MERS also conducted midterm and final evaluation (30 cluster) surveys. The following paragraph describes the summative outcomes of these evaluations.

Mother's literacy: endline survey results showed 12% increase in mother's literacy rate (34% in baseline to 46% in endline) in Kavre while a slight decrease in Rasuwa.

Breast feeding/nutrition: there is slight decrease in 'exclusive breast feeding' practices in both districts however initiation and persistence of breastfeeding practices has increased. Knowledge of Vitamin A and practice of feeding Vitamin "A" has improved in both districts.

Diarrhea: there is significant increase in mother's knowledge about diarrhea (correctly defined diarrhea *'three or more watery stool in 24 hour')* 11% and 21% respectively in Kavre and Rasuwa. With regards to diarrhea cases management in both districts it was noted that the percentage of mothers, who continued giving fluids including ORT, and foods have marginally increased. Mothers taking their child to nearest health facility or hospital have also increased.

There has been a significant increase in the knowledge and treatment seeking behavior among care takers (mothers) whose children are suffering from ARI.

Percentage of mothers who could recognize four child vaccines has increased (77% to 83%) in
Kavre. Women who knew that measles vaccine should be given after nine months of age has increased significantly in both districts 48% to 58% and 17% to 65% respectively.

Results of child immunization coverage shows inconsistency findings in both districts, which is illustrated on the following table (Table 9).

Table 9. Immunization Coverage within Three Surveys Coverage by Districts

INDICATORS		Kavre			Rasuwa	
		Base Line	Mid Term	End Line	Mid Term	End Line
EPI Access	Card	43.3	31.6	35.6↑	14.9	25.9↑
	Self Reported	92.3	95.6↑	62.7	80.6	58.8↓
EPI Coverage	Card	41.3	32.4	34.1↑	14.2	25.2↑
	Self Reported	82.7	93.4↑	62.8	74.6	57.3↓
Measles Coverage	Card	40.4	27.9	34.1↑	10.4	24.4↑
	Self Reported	40.3	86.0↑	61.2	73.1	54.2↓
Drop Out Rate	Card	4.4	-2.3↓	4.3↑	5.0	2.9↓
	Self Reported	-	1.5	0.0	7.4	2.6↓
Overall Drop Out	Card	8.7	11.6↑	4.3↓	26.3	5.8↓
Rate	Self Reported	13.4	10.0	2.5↓	8.4	8.9
Complete	Card	37.5	25.0	35.6↑	10.4	25.9↑
Immunization	Self Reported	77.9	84.6↑	64.3	70.9	74.7↑

Source: Rapid KPC Survey

However the percent of mothers with knowledge that five doses of TT required for life long protection was increased from 30% to 37% in Rasuwa and decreased from 54% to 38% in Kavre. But in real practice it is observed that mothers who had at least two TT dosages prior to the birth of the child has increased in both districts.

Percentage of using a modern contraceptive method has increased from 38% to 56% in Kavre but the same is not true in Rasuwa. Similarly the knowledge of timeliness of ANC care has increased in Kavre. Pregnant mothers who have had one or more ANC visit has increased in both districts (69% to 81% in Kavre and 34% to 39% in Rasuwa). Percentage of assisted delivery by trained health personnel has also increased in Kavre while PNC care increased in both districts.

There has been significant increase in the knowledge of modes of HIV/AIDS transmission among WRAs - 49% to 64% in Kavre and 16% to 33% in Rasuwa. Likewise the women who

can name condom use as a prevention means of AIDS/STD transmission has also increased in both districts.

The overall performance in both districts, the 'exclusive breastfeeding practices', and the 'knowledge of Tetanus Toxoid' need to be addressed in future program designing.

Intervention Three: VDC Health Empowerment Program (Annex 11)

1. Target and Achievement

There has been significant achievement in this intervention of the project. The target populations are members of sub health post support committees (S/HPSC) of 46 VDCs in Kavre. The S/HPSC is comprised of 6 members chosen from the respective VDC. This government mandated VDC level health committee is an effort to decentralize the health delivery system to the grass root level and to empower the VDCs to plan, implement, monitor and evaluate all health related activities at their level. Effective and appropriate use of the annual health budget (5% of total VDC budget) allotted to health, active mobilization of VDC level health volunteer, and implementation of public health activities at the VDC level in a planned way are other objectives of the S/HPSC.

The general objective of this VDC Health Empowerment intervention was to mobilize, train, and support the S/HPSCs in the program area thus enhancing the capacity of sub health post support committees in 46 VDCs of Kavre. The project trained and provides technical assistance empowering 46 S/HPSCs to plan, implement, monitor and evaluate community health activities at the VDC level. The main activities carried out were, training on VDC health service management to the members of SHPSC, provide assistance in monthly, four monthly, and annual review and planning meeting. All planned activities were successfully implemented in Kavre. As the MoH assigned 6 members committee does not cover the whole VDC (there are 9 wards in a VDC) with approximately 500 people, ADRA increased the size of committee from 11 to 13 ensuring proper representation from the concerned sectors in the VDC.

ADRA conducted Community Health Empowerment Training of Trainers (TOT) to all ADRA Family Health Project's field staff and DHO staff. The objective of TOT was to create common understanding of the program, to raise the motivation level of the worker and subsequently bring the desired change in their performance.

1.1 Major Achievements carried out by S/HPSC

- SHP buildings were constructed at 7 VDCs through community participation
- High performing health volunteers were rewarded for their excellent work by S/HPSCs during VDC annual review and planning meeting
- FCHVs and TTBAs were equipped with first-aid medicine, safe delivery kits, and other required materials such as nail cutter, torchlight, and a set of batteries by S/HPSC.
- Implemented revolving community drug scheme at S/HP by 11 VDCs to make year round availability of essential medicine to the local communities.

- Community water sources are cleaned, protected, and treated with bleaching powder 2-3 times per year regularly in many VDCs.
- VDCs have been allocating 5 % of human resources budget regularly for health activities.
- S/HPSCs are providing health education to school students and distribution of deworming tablets-Mebendazole.
- S/HPSC members are helping health volunteers to conduct MGMs
- S/HPSCs are conducting 4 monthly meetings to increase interrelationship and to generate active participation of all health volunteers.
- Strengthened community immunization clinic and PHC Outreach Clinics at 14 sites
- Established S/HPSC fund at all trained S/HPSC
- Established ward health fund at Saradabatase VDC
- Constructed 196 smokeless stoves.
- Constructed 1,185 toilets in program area
- S/HPSCs supported ADRA's monthly mobile clinic at their respective VDC
- Conducted health education training to THs at 3 VDC.

1.2. Impact of the Program

The most remarkable impact of the program is the enabling of S/HPSC's knowledge and skills to identify, prioritize, implement, and monitor their own health, which will encourage increased community participation, transparency, and foster ownership. This will not only stimulate the community to take action in health activities but also feel responsible for the health delivery system in their respective VDCs. In addition, the committee members have been able to prepare a comprehensive plan of action (PoA) and monitor the progress on their own. The program has also transferred the skills to search alternative resources to accomplish the planned activities.

The VDC health empowerment training program has helped development workers and leaders to internalize health as a center of all development efforts. VDC health promoting activities are slowly initiated at the VDC level to raise the health status of community. They meet on a regular basis and discuss how they can do better. They perform health planning before VDC assembly so that budgets for health activities from VDC development budget are easily tapped.

S/HPSC fund has been established in most of the ADRA trained (43) S/HPSCs - an important step taken to achieve self-sufficiency. In addition, S/HPSC has been creating a working environment to health workers by fulfilling the basic necessities of health institutions (S/HP) and to health volunteers by providing necessary support and rewards for their good work.

1.3. Lessons Learned

- The expansion of committee members greatly helped to get proper representation from the important sections in the community.
- Committee members have understood the government health service delivery mechanism at the community level and are motivated to strengthen the system.
- Committee members have felt a sense of ownership of the health post and community health activities.
- Committee member monitored S/HP resources including health volunteers to ensure that they are properly mobilized and used for the well being of community people.

- Committee members have easy access to the information through the installment of health indicator board (community monitor board) at the health facility.
- Involvement of DHO staff in the training and review meeting helped to deal with issues related to DHO and health facility.

1.4. Problems/Constraints/Solutions

- VDC Chairman, and S/HP in-charge influence the selection process of committee members on the basis of political and professional affiliation. To overcome this problem ADRA, in close coordination with the DHO, has developed a criterion for the selection of committee members. ADRA FRs facilitate the S/HPSC restructuring meeting to make sure that the criteria are followed to select the committee members.

- Lack of and frequent transfer of health facility in-charges also hampers the activities. This is beyond ADRA Nepal's control. However, the new comers are oriented about the whole process by ADRA Nepal's FRs.

- Supervision, follow up, and monitoring from DHO to the support committees have been less frequent than expected. Mobilization of DHO staff for this activity has often been a slow process.

- There is a lack of resources in the committee to implement the activities in the community. S/HPSC members are guided to plan their activities according to the available resources. They are also advised to utilize the resources optimally in the community for the implementation of community health activities at the VDC.

- Despite the committed member's efforts the meetings are delayed, participation is incomplete and seriousness of work is not found in all committee members. All committee members are not equally active. Committee members show their commitment at the time of training. There is no provision of any allowances to the committee members for their work.

2. Reasons for Deviation

- One additional S/HPSC training was conducted in Taukhal S/HP under Panauti municipality. The training was not planned for urban area (Municipality) but based on the request of the community it was implemented.

- Annual meeting of S/HPSC (46) was planned for each year. But up to the second year of operation only 15 S/HPSC were trained. The maximum number of trainings was completed in the third year (23). The annual meeting was done only after one year of initial training. During the five-year period 85 meetings were sponsored and facilitated in Kavre.

3. Reports of Investigation

3.1 Excerpts from Mid Term Evaluation

VCHEP: The most remarkable strength of the VDC health empowerment program was that it had helped the SHPSC members to assume their responsibilities towards the functioning and

development of the health posts. In addition, the program had been instrumental in formulation of annual plans of the health post and agenda for meetings, which had reminded of the responsibilities of the members, stimulated them do participate in the health post activities and activated them to search alternative sources to support the planned activities.

3.2 Excerpts from Final Evaluation

The program has responded to the mid-term review's recommendations.

VDCHEP: An innovative/ambitious project aiming to make a reality the difficult process of community empowerment and to put into practice the sustainability concept. The VDCHE project utilized solid principles and participatory approaches along with sound materials and training skills. The activities conducted and achieved by S/HPSCs and communities were extensive and impressive and will have a long lasting effect at the local level. Utilization of Health Facilities has increased as a result of the VDCHE training. This is likely to have resulted partly from increased community control and confidence in their local HF, a notable achievement in the short and longer term, and one which will subsequently prevent illness and increase health promotive activities.

3.3 Operation Research on VDC Health Empowerment Program (VDCHEP)

MERS conducted the operation Research on intervention 3 - VDCHEP. The immediate objective of this research was to provide an insight to the program inputs during intervention and the ultimate objective was to provide effective ways of implementing the VDC health empowerment program. The specific objectives were as follows:

- To find out the strengths and weaknesses of program implementation (S/HPSC formation, pre-training meetings, S/HPSC initial training, and regular meetings) from the perspective of S/HPSC.
- To assess the ability to identify community health needs, develop a plan for solving problems, implement the problem-solving process, monitor planned activities, and evaluate the activities annually through the S/HPSC level.
- To compare the empowerment capability of the S/HPSC activities during year 1 of the project with that of subsequent years.
- To determine the extent of participation of women in the S/HPSC activities.

The FGD findings of the research showed that the VDC Health empowerment program was meant to improve the health of the community through S/HPSCs by means of planning and implementing all health activities under the umbrella (S/HPSC) and by reaching out to each individual in the community. Although the meetings are important for assessment of the progress of the planned activities some committees were not capable to monitor adequately the planned activities through periodic meetings. Commitment of the S/HPSC members is crucial. The members of the committee felt that there was adequate representation from each ward of the VDC including women. Most of the S/HPSCs activities are focused on maternal and child health. Some of the committee were not only less involved but also did not participate in the improvement of the health of the community. After the research, they became clearer about the roles and responsibilities of health volunteers, health workers, and the committee itself.

After implementation of the S/HPSC activities by a trained committee, many changes in knowledge and practice were noted in discussions with both the committee and the community. Although there have been a lot of changes, the documentation of the activities was observed to be poor. Improved coordination between S/HP staff and the community was observed.

Most of the committees established a S/HPSC fund with separate bank accounts. They are capable of managing certain community health activities through the fund. They managed the registration fee, free services for elderly people, rewards for the volunteers, rewards to the FP clients (permanent sterilization) and supplies and medicines for the volunteers. The committee is becoming self-reliant in certain activities. They have been made aware of education by the volunteers and are encouraged to enroll in ADRA-conducted women's literacy classes.

Although the majority of the FGD participants consistently mentioned the importance of maintaining the health indicator board (community monitor board), very few were properly maintained and updated. But some have utilized it for databased planning during the monthly, four-monthly, and annual review and planning meetings. That means that the committees still need to be encouraged to update and utilize the data.

As a result of this operation research, which includes program (process) recommendations, it is hoped that the results of this OR will help strengthen further program implementation and hence replicate it in other areas.

3.4 Demographic Status of New Family Planning Method Acceptors

MERS also conducted a "Demographic Status of New Family Planning Method Acceptors" study. The primary objective of this study was to explain the general characteristic of new FP acceptors and the specific objectives were as follows:

- To see the ethnic, education, occupation, family background of FP acceptors
- To see the parity of FP acceptors (Including Sterilization and Temporary)

The face sheets used by ADRA/Nepal PHC were a major tool. Both sterilization and temporary method face sheets were entered into a statistical program EPI_INFO and later transferred into the SPSS program for further analysis.

The face sheets of 7,804 new FP method acceptors from 1998 to 2001 (out of 8,125) were recorded. During this 4-year project period about 42% (n=3,241) clients accepted permanent sterilization and remaining 58% (n=4,563) accepted temporary FP methods.

The mean age of FP acceptors at the time of accepting FP method (all methods) was 26 years for women and 29 years for men. With regard to parity, the majority have two or three children (mean 2.56) (Figure 11). However it was noted most of them had two sons and one daughter. It was found that after having two sons most of the limiters accepted sterilization. It indicates the son preference in the community.

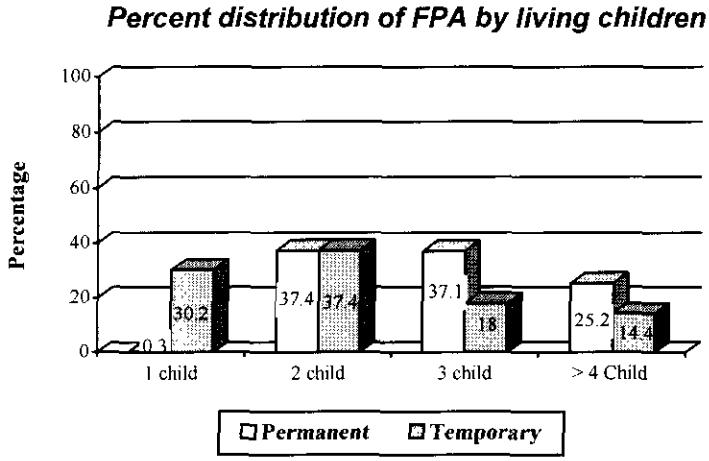


Figure 11. Distribution of FP Acceptors by number of living child

More than half of the women and about 20% of men were illiterate. About 44% women and 94% men were engaged in 'real' income earning activities, which clearly revealed the lower status of women in the community and the gender disparity in the work force.

Based on the findings the following recommendations have been formulated.

- The FP program should be focused on people of under privileged (backward) ethnicity.
- The community should be aware of gender so as to advocate massively on sterilization after having two children, either son or daughter.
- Focus on the reproductive age of women when implementing literacy classes.
- The women need to participate in income earning activities because it empowers them and enables them for decision making. Therefore it would be advisable that women's income generating activities should be initiated.

PART III
Rasuwa District

Intervention Two: Maternal and Child Health

1. Target and achievements

ADRA Nepal successfully completed its program activities in Rasuwa despite the challenge of rough geographical terrain, remoteness, difficult access, extremeness of weather, and the vastly scattered population. Program interventions activities were carried out through ADRA Nepal's office in Kalikasthan. Field activities covered all 18 VDCs of Rasuwa, which is divided into two geographical areas called Upper Belt in the north and Lower Belt in the south. Lower belt has most of the population and is readily accessible when compared to Upper Belt. Clinical services were delivered through ADRA Nepal's static clinic in Kalikasthan and mobile outreach clinics.

1.1. Field Activities (Annex 12)

1.1.1 FCHV/TBA/TH

During the project period ADRA conducted initial trainings to 78 FCHVs. Subsequently each year the FCHVs were supported with 2 review meetings. ADRA staff also made regular supervision visits - 582 times during this project period. During the supervision visits checklists are used. FRs at the field checks FCHV, TBA, and TH filled checklists for its in formativeness and completeness. On sight coaching was offered as per need. ADRA supported DHO in conducting TBA supervisory meetings. TBAs not trained by ADRA were also followed and assisted with prior agreement from DHO. Each TBA receives 10 SDK to conduct safe delivery in the community. The role of TBAs in delivering safe motherhood services is still important and cannot be overlooked, as most of the HPs are not manned by ANMs in Rasuwa.

1.1.2 Mothers Group Meetings

MGMs are a forum for discussing MCH related education. 171 of the planned 313 MGMs were conducted through FCHVs during this project period. Mothers in the lower belt usually held MGMs more regularly then in the upper belt - probably due to the isolation and travel distances in the Upper Belt. During the training of S/HPSCs, MGMs are given due priority and importance. Reports indicate that the number of MGMs has slowly increased. ADRA field staff attend and revitalize weekly MGM through FCHVs.

1.1.3 Health Quiz and Important Day Celebrations

There has been very satisfactory accomplishment in health quiz competitions. In total 162 quizzes were held. Health quizzes are considered as one of the effective mediums of delivering health messages across the community. S/HPSC members, FCHVs, teachers and local leaders supported the quiz. The quiz program was initiated from the third year of the project in Rasuwa. In the Upper Belt it is quite difficult to conduct quizzes as the villages are scattered wide apart. FCHV in lower belt of the district often demand more quizzes to be held.

ADRA Rasuwa managed to celebrate 19 important day celebrations. Themes such as Condom and AIDS day, National Vitamin A distribution day, Women's day, and Safe motherhood day etc.

1.1.4 Community Health Training

S/HP refresher trainings trained 83 (of 125) different health staff of Rasuwa. VDC health orientation training to 17 VDCs, FCHV TOT to 23 DHO/ADRA staffs, initial drop out training to 78 FCHVs, and frequent FCHV/TBA review/supervisory trainings were completed within the project period.

FCHV Review Meeting: FCHV review meetings are important occasions for reviewing their activities and an opportunity to refresh/update knowledge. During the project period FCHV review meetings were conducted by DHO and ADRA one time per year.

ARI Activities: ADRA in joint collaboration with JSI and DHO supports ARI program in Rasuwa. ADRA FRs make follow-up visits to trained FCHVs, VHW/MCHWs, even the health facilities using special supervision formats developed by JSI for monitoring. ARI checklists are collected from FCHV-ARIs during follow-up visits. There was no significant difference in knowledge and treatment skills between FCHVs and VHW/MCHWs. Overall knowledge and skill of these FCHVs on ARI was found to be very satisfactory. Most FCHVs know the respiratory rate by age and can quote two of the six danger signs of referral. Many FCHVs have Cotrim supply during the follow up visit.

1.2 Women's Health Literacy Program (Annex 13)

1.2.1 Basic Literacy Level: (Figure12)

By the end of the project period 1,895 of planned 1,200 women completed BLL in Rasuwa

Objective: Upon the completion of the Basic Literacy Course, 80% of the participants will be able to recognize the signs and symptoms of severe ARI.
Achievements: *Objective not met by 8% (end line) in Rasuwa, achievement was 72%.*

Objective: Upon completion of the Basic Literacy Course, 80% of the participants will have knowledge of appropriate management techniques for non-severe diarrhea.
Achievements: *It is found that the rate was 76.5 % in Rasuwa, objective not met.*

Objective: Upon completion of the Basic Literacy Course, 90% of the participants will pass the Basic Literacy examination.
Achievement: *It is found that the pass rate was 84.3% in Rasuwa, objective not met.*

Objective: Upon completion of the Basic Level Literacy Course, 80% of the participants will pass the health knowledge assessment.
Achievement: *It is found that the pass rate was 90.7% in Rasuwa, objective over met.*

1.2.2 Post Literacy Level:

By the end of the project period, 1,007 of 1,200 women in Rasuwa completed Post Literacy Classes
Objective: Upon the completion of the Post Literacy Course, 90% of the participants will be able to recognize the signs/symptoms of pneumonia.

Achievements: *It was found that 98% of participants in Rasuwa were able to recognize these signs/symptoms, objective over met.*

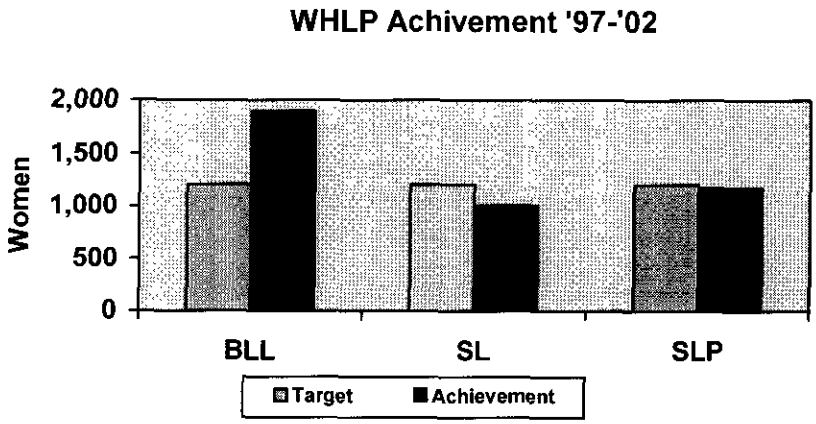


Figure 12. Distribution of Literacy participants by literacy level, Rasuwa

Objective: Upon the completion of the Post Literacy Course, 90% of the participants will have knowledge of appropriate management techniques for non-severe diarrhea.
Achievements: The rate was found to be79% in Rasuwa, objective not met.

Objective: Upon completion of the Post Level Literacy Course, 90% of the participants will pass the Second Level Literacy examination.
Achievements: T*he pass rate was found to be 92% in Rasuwa, objective over met.*

Objective: Upon completion of the Post Level Course, 90% of the participants will pass the Health, Environment and Forestry knowledge.
Achievement: *It was found that 98% passed in Rasuwa, objective over met.*

1.2.3 Third Level Literacy:
By the end of the project period, 1,173 of 1,200 women in Rasuwa completed Third Level Literacy Classes

Objective: Upon completion of the Third Level Literacy Course, 90% of the participants will pass the Third Level Literacy examination.
Achievement: *It was found that 98% of participants had passed the exam in Rasuwa, objective over met.*

Objective: Upon completion of the Third Level Literacy Course, 90% of the participants will pass the Health, Environment and Forestry knowledge assessment section.
Achievements: *Rasuwa 98%, objective over met.*

1.2.4 Successes

- LOCEC participants of VDCs conducted awareness campaign against smoking and alcohol.
- Many literacy participants gave up smoking after enrolling.
- LOCEC participants constructed water shield toilets (144), Pit latrines (120), compost pits (14), and smokeless stoves.
- There is an increase in ANC check ups and use of FP devices

- Most of the LOCEC participants have cleaned the water source, and roads (8,512 meters).

1.3 FP/MCH Clinic Kalikasthan (Annex 14)

Approximately 16,700 client visits to services delivery points were made during this project period. There has been a 20% decrease in the client flow in the clinic over the years (Figure 13). This is considered to be due to the increased insecurity in the district which deterred travel and also reduced the services available at the clinic.

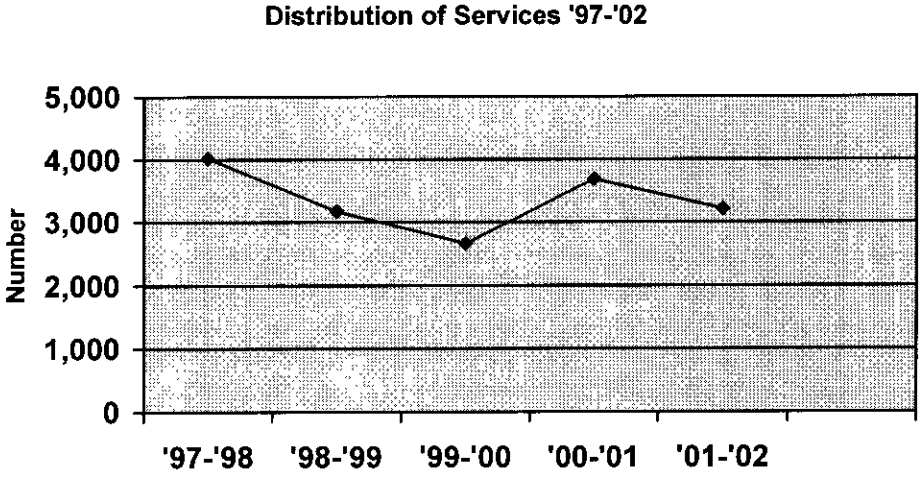


Figure 13. Distribution of client visits by year

Services wise the highest percentage of clients came for 'other' services followed by under fives (Table 10). Women and children comprise 70% of total service delivery.

Table 10. Distribution of planned achievement by service, Rasuwa

Activities	Number	Percent
Antenatal care	1412	8%
TT Immunization	458	3%
Child EPI	322	2%
<5 children care	3833	23%
STD	316	2 %
Gyane	763	5%
Family Planning Related	3,479	21%
Others	6,164	37%

1.3.1 Antenatal care and TT immunization

There has been a very satisfactory ANC activity in Rasuwa (Figure 14). The clinic provided ANC Care to 1,412 pregnant mother times. About 54% of clients have had more than two visits. There was a 133% increase in the number of ANC cases. Women from the neighboring district, Nuwakot also came to the clinic seeking ANC care, which suggests the popularity of the clinic. All these were provided with iron tablets and TT immunization along with health

education on nutrition and personal hygiene. With the increase in ANC cases number of TT immunization also increased.

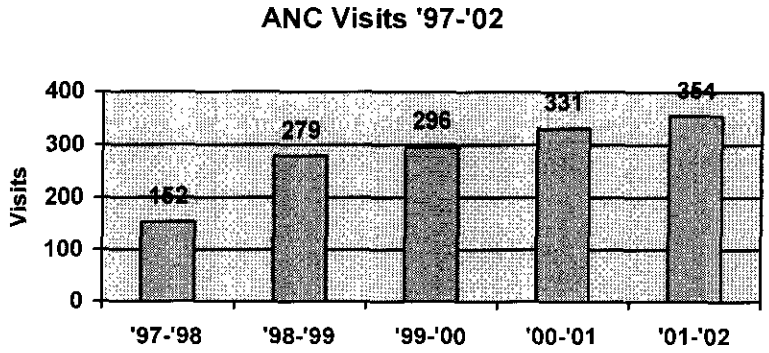


Figure 14. Distribution of ANC visits by year

1.3.2 Under 5 cases and Child EPI

Under five-service activity has been slightly decreased over the years. A total of 3,833 children visits were reported during this project period. There is a 681% increase in child immunizations. Number of child immunization visits to different antigens increased from 16 in year 1 to 322 in year 5. Almost 40% of the beneficiaries are female babies.

1.3.3 Gyne and Sexually Transmitted Infections

More then 40% of 316 women seeking 'women' related services had clinically diagnosed STIs. Two retention of placenta cases were also managed.

1.3.4 Family Planning Service

About 688 men and women accepted new contraceptive methods during this project period. About 95% of new acceptors were females. Almost 90% of all new acceptors were spacers. Depo being the most popular spacing method followed by NP®. About 2,800 CYPs were gained during this project period. About 21,000 condoms were distributed from the clinic.

1.4 Mobile Clinic and Laboratory Service (Annex 15)

Mobile clinic targets were over met in Rasuwa. 93 out of 80 planned mobile visits were accomplished. About 3,300 services (patients) were delivered in this very remote part of the project area. More than 95% of the beneficiaries from these outreach mobile visits were women/children, underserved, and hard to reach groups of this rough terrain part of the country.

There has been some activity in the ADRA laboratory at Kalikasthan but the laboratory service could not be sustained to a full phase due to technical reasons. However, simple tests like Hb, urine pregnancy test using test kits, urine and stool R/E, and VDRL screening using test kits were carried out.

2. Reasons for Deviation

TBA TOT Training: No such training was carried out. However, 8 ADRA and DHO staff took TBA orientation training. The reason for not conducting ToT was due to the lack of resource persons and participants to undertake this training. The scenario has changed with

the posting of ANMs in all the vacant positions by the MOH and shifting of policy to scale up MCHWs instead of TBAs as the research has shown very limited role of TBAs in reducing MMR.

Number of mobile visits exceeded by 13 - 93 mobile visits were made out of planned 80 in Rasuwa.

3. Report of Investigation

3.1 Excerpts from Mid Term Evaluation

Mothers did not often see children dying of diarrhea in the last few years. This might be the result of appropriateness of health education provided by field workers and literacy class facilitators.

Few women in Rasuwa (Upper Belt) were reluctant to give solid foods during diarrhea. Knowledge regarding CDD is required more in Upper Belt of Rasuwa.

Interview with the mothers indicated that they knew the child should be taken to health facilities when s/he develops pneumonia. This information was imparted to the mothers by FCHVs. Most of the mothers knew when the child should be taken to hospital, PHC or FCHVs. It was reported that FCHVs had not heard of any deaths due to pneumonia since they started teaching on treatment of pneumonia.

The FCHVs and health workers trained in ARI and CDD were playing important roles to improve child health in the rural and remote areas. Mothers group meetings conducted by FCHVs had been instrumental in educating mothers themselves on caring of children at home. Provision of health post and sub-health posts in the VDCs with staff trained by ADRA was found to have strengthened child health services delivered by these facilities.

In recent days the Ministry of Health is not encouraging the training of TBAs as it has been found that they are not contributing to reduce the maternal mortality rate. So, the original activity of the TBA training needs to be dropped and changed to competency based training of the MCHWs and ANMs in Rasuwa district.

In Rasuwa the team visited the Betrawati mobile clinic site. An active support committee has been formed in this area recently. The committee has recently arranged an attractive notice board depicting information about the mobile clinic. This notice board provides the date of clinic operation and services available. It was learnt that the board had played a significant role in increasing the number of clients visiting the static clinic. This is a static clinic run by ADRA and provides good family planning and maternal and child health services. The nurses and paramedical staff run the clinic, which is visited by 15-20 clients every day.

3.2 Excerpts from Final Evaluation

Monthly Mothers' Group Meetings: The community has benefited greatly from the increased knowledge of mothers on STDs/AIDS, TT, ANC and condoms. This has occurred through regular, ADRA assisted meetings.

Access to child health services had also improved during the project period as in the example of FCHVs having been equipped with knowledge, skills and medicines to deal with ARI. Training was given to THs, FCHVs, community leaders, health workers and mothers' groups as outlined in project strategies; training was not given in the case of TBAs in Rasuwa. Treatment and/or referral seems to have improved in both districts such that many venues reported that no child mortality has occurred in recent years.

During the team's visit no mother could relate to any child or maternal death in her area in recent years. This is interpreted, as more frequent ANC and timely referral of complicated cases by FCHVs and MCHWs. FCHVs working at ward level were able to identify and treat cases of pneumonia among children in the villages.

The women enrolled in classes have been from marginalized communities. ADRA made a huge effort to decrease barriers for marginalized women to attend the classes.

Monitoring of volunteers (e.g. FCHVs) has occurred within VDCs themselves (by S/HPSCs) – this is not only more feasible and cost effective, but is likely to achieve better longer-term outcomes for the community

The final review team felt that the literacy/NFE programs produced better results than the other classes in the district that were supported by the MOE and run by other organizations.

Counselors counseled the clients in ADRA clinic very effectively. They have a separate room for counseling in the Rasuwa clinic. Generally the clients seemed satisfied with the information given and chose to obtain FP services from the clinic.

Intervention Three: VDC Health Empowerment Program (Annex 12)

1. Target and achievements

Pre-training and initial training of 18 S/HPSCs (out of 17 targeted) were started from year 3 of the project in a phased manner. Last training was conducted at Langtang in the final year. The training has increased the capacity of the committee at VDC level especially in the problem of resource identification, prioritization, advocacy, planning, and implementation of plan. VDCHEP is a step further to fostering the Local Governance Act envisioned by the government and a clear way forward to attain a sustainable health program in the communities.

To save time the committees merged S/Husks monthly meetings and 4 monthly meetings. 14 of 18 planned annual meetings were held in the initiation of the S/Husks during the project period. FRS contributed in planning, implementing, and monitoring review and evaluation of health activities. One of the positive outcomes of the training was realized when VDC chairmen raised the funding issue and demanded for resource allocation for their VDC aimed for health activities at the DDC meeting. This showed the committee members increased awareness and responsibility for their health.

Program Impact

- Community participation in health activities increased

- Some of the S/HP have opened S/HPSC fund accounts in the bank.
- S/HP agreed to buy and supply first aid kit boxes and medicines to FCHVs.
- VDC committed to continue ARI program even after donor support ceases.
- S/HPSC of Lahare and Dandagaun decided to charge emergency fee after office hours.

2. Reasons for Deviation

18 of 17 S/HPSC were trained in Rasuwa. As there are 18 VDCs in Rasuwa it was difficult to leave just one VDC without this training.

3. Report of Investigation

3.1 Excerpts from Mid term Evaluation

The SHPSC training process was most analytical and concrete since the participatory rural appraisal (PRA) techniques followed to develop the health need assessment and resource identification had provided the participants to observe the related situation first hand and discuss critically. The expertise in organizing such a useful training on the part of the ADRA resource persons is laudable.

PART IV

Monitoring and Evaluation and Research Activities

1. Monitoring

There was regular monitoring of all program progress on monthly and quarterly basis in the field as well as in the clinic. Regular technical progress reports were prepared and submitted to the donor. Annual performance reviews and planning meetings were held every year to see the progress made in terms of set goals and objectives, lessons learnt during the project implementation and short term impact seen in the community. Monitoring/evaluation and research unit developed a local field registration system in target areas at Kavre ensuring that adequate data is available for monitoring project effectiveness. Midterm and final evaluation of the project was carried out in the initiation of this section.

'Family Planning (FP) Training' was monitored on the basis of the number of training sessions conducted for government and non-government FP service providers. End of training package evaluation by participants was a constant activity encouraged.

'Health Services Delivery Activities' were implemented through the FP/PHC clinic Banepa, Kalikasthan Rasuwa and mobile clinics in various places at both districts. In-house quality assessment of the FP/PHC and mobile clinic services were carried out periodically using various checklists, observation, and interviews both in Rasuwa and Kavre districts. Similarly monitoring of 'cold chain' at Operation Theater and vaccine utilization and wastage rates were assessed. The findings of all these activities were disseminated immediately to those concerned for improvement.

Field Activities were tracked with the use of a set of supervision checklists and recording and reporting forms. These checklists and forms were frequently revised after implementation because it has helped to collect the information/data from the field level. The pre and post-test session evaluations in the various level training such as TBA, TH, FCHV, FP Counselor, and S/P staff were carried out and recommended accordingly.

Supervision and monitoring system was established at different levels. FP Counselors monitored FCHVs, TBAs, and THs activities; FRs monitored FP Counselor, FCHVs, TBAs, THs and literacy classes; Field, Literacy, Training officers monitored the activities of FRs and literacy supervisors activities; and Project Director monitored the activities of the officers.

The **'Women's Health Literacy'** activities were monitored frequently through literacy and education officers and FRs in both districts. The process of selecting classes, participant, and facilitators were monitored. The daily attendance of participants and demographic and behavioral information of each literacy participants were documented, updated and monitored regularly. The literacy officers monitored the teaching methodology to make sure that all the adult learning principles were followed.

ADRA has developed a checklist and guideline to collect BLP participants' demographic and behavioral information, which has helped to analyze the key indicators and to identify practical and behavioral changes of the participants before and after classes were attended.

The **'VDC Health Empowerment (VDCHE)'** program was monitored on the basis of the number of training sessions conducted, number of action plans developed by the committee and number of follow up meetings held in each S/HPSC. (see Annex 4)

MER section provided support to the community empowerment officer to document the process of S/HPSC formation, pre-training meetings with committee members, health service management training to the committees and periodic meetings with them (monthly meeting, quarterly meeting, semi-annual, and annual). MERS has kept the information and data regarding the training, action plan prepared and implemented, and progress made by each S/HPSC in Kavre and Rasuwa.

2. Evaluation

Midterm and Endline KPC surveys were conducted.

3. Research

The following operation/action research projects have been conducted during the project period.

- Yearly Field Registration Data Analysis
- Operation Research on VDC Health Empowerment Program
- Study on Trained Traditional Healer
- Demographic Status of New FP Method Acceptors

4. HMIS

ADRA Nepal has been able to collect data from the field level through FCHVs and FCs. VDC level information is analyzed and disseminated to the program managers in ADRA, DHO, and also back to the VDC for appropriate use.

ADRA Nepal

ANNEX 1

Distribution of Accomplishments by Intervention, ICBFHP, '97-'02

		Kavre		Rasuwa	
Activities	**Units**	**5 YR Target**	**Achievement**	**5 YR Target**	**Achievement**
Intervention 1 (FPT)					
Family Planning Training	Person	480	379	NA	NA
Intervention 2 (MCH)			108		68
CYP	CYP	80,000	86,660	15,000	10,151
Mobile Clinic Visit	Times	470	383	80	93
VDC Health Orientation	VDC	NA	NA	18	18
Support ARI Initial Training to FCHVs	Person	NA	NA	162	157
TBA TOT (TBA Orientation)	Person	NA	NA	17	8
S/HP Staff Refresher Training	Person	250	156	125	83
FP Counselor Refresher Training	Person	54	56	NA	NA
Quiz Contest	Times	216	490	162	162
Street Drama Show	Times	50	51	25	22
Basic Literacy program	Person	3,125	3,674	1,200	1,895
Post Literacy Program	Person	3,125	3,219	1,200	1,007
Self-Learning Literacy Program	Person	3,125	2,703	1,200	1,173
Intervention 3 (VDCHE)					
S/HPSC Initial Training	S/HPSC	46	47	17	18
S/S/HPSC Annual Review Meeting	Times	46	85	17	14

ADRA Nepal

Field Program, Kavre

ANNEX 2

Distribution of Field Activities by Year, '97-'02

SN	Activities	Unit	5 YT	Y1		Y2		Y3		Y4		Y5		Total	
				T	A	T	A	T	A	T	A	T	A	T	A
1	Counselor Monthly Meeting (Times)	Batch		120	120	120	120	108	108	108	108	117	118	**573**	**57**
2	Support Mother Group Meeting by FR	Group		72	62	160	111	75	75	103	103	60	55	**470**	**40**
3	Health Quiz Contest	Group	216					180	171	198	182	145	137	**523**	**49**
4	Street Drama	Show	50			20	20	10	11	5	4	15	16	**50**	**5**
5	Urban Health Education	Times						20	13	29	25	30	28	**79**	**6**
6	National Health Days Celebration	Times		4	4	4	4	4	4	4	4	4	5	**4**	
7	Field Register Data Presentation	VDCs								46	44	54	40		
8	Support In Vitamin 'A' Program	Times							2	2	2	2	2	**2**	
9	Co-ordination meeting with (HC/HP/SHP/INGO/NGO)	Times		72	64	87	74	0	50	36	83			**195**	**27**
	FCHV program														
10	**# of Mother Groups (600)**														
	Conducted Mother Groups Meeting (Times)	Events			5,159		4,825		4,810		5,412		5,879		**26,08**
	MG Meeting Conducted More Than >=11 Participants	Group			5,083		3,333		3,601		4,866		5,429		**22,31**
	Support to Mother Group Meeting by FP Counselors	Group			NA		NA		NA		3,484		3,722		**5,41**
	Distribution of Condom (pieces)	Pieces			4,185		5,971		6,160		11,856		14,970		**43,14**
	Distribution of Condom (person)	Person											1,063		**1,06**
	Distribution of Pills (cycle)	Cycle			1,132		841		779		946		671		**4,36**
	Distribution of Pills (person)	Person			NA		NA		NA		NA		677		**40**
	Distribution of Jeevan Jal	Pocket			2,306		2,723		2,345		2,845		2,273		**12,49**
	Home visit to Mothers by FCHVs (600 FCHVs)	Number			6,743		10,641		13,215		14,544		10,524		**55,66**
	Refer for Permanent FP Use (by FCHVs)	Number			1,051		1,356		1,070		481		435		**4,39**
	Advice for ANC check-up	Number			2,314		1,579		6,039		6,438		5,511		**21,88**
	Advice for SDK use	Number							2,947		6,433		5,402		**14,78**
	Support in Immunization Clinic (by FCHV)	Times			1,638		1,874		2,161		2,059		1,664		**9,39**
12	**TBA Program**														
	Total Pregnant Women	Number			6,450		7,076		7,527		7,143		12,156	0	
	ANC Check up (by TBAs)	Times			3,396		3,511		3,052		3,545		3,484	0	
	High Risk Identified and Referred for ANC Check up	Number			294		221		151		715		292	0	**1,67**
	Total Deliveries	Number			3,330		3,837		4,125		3,614		3,462	0	**18,36**
	Delivery Assisted (handled)	Number			1,391		1,357		1,229		1,237		1,032	0	**6,24**
	Distribution of SDK	Number			558		863		1,040		1,171		1,190	0	**4,82**
	SDK Used	Number			972		921		1,053		1,117		982	0	**5,04**
	Child Referred for Immunization	Number			2,508		3,127		2,817		3,433		2,696	0	**14,58**
	PNC Visit	Number			1,534		1,631		2,418		1,783		1,478	0	**8,84**
	Advice for FP Methods Use	Number			1,142		1,204		1,594		4,482		4,393	0	**12,81**
13	**TH Program**														
	Patient Checked	Number							4,727		30,435		25,425	0	**60,58**
	ARI Cases Referred	Number							599		4,231		3,429	0	**8,25**
	CDD Cases Referred	Number							383		1,327		1,267	0	**2,97**
	Child Immunization Referred	Number							454		2,520		1,708	0	**4,68**
	Referred for Sterilization	Number							14		128		71	0	**21**
	Malnourish Child Referred	Number							189		847		417	0	**1,45**
	Others Cases Referred	Number							654		4,503		6,946	0	**12,10**
14	**Supervision to**														
	FCHVs (times)				218		407		3,164		6,528		6,783	0	**17,10**
	TBAs (times)				142		344		2,698		5,461		5,461	0	**14,10**
	THs (times)				63		85		1,059		2,103		2,020	0	**5,33**
	Counselor (times)				271		364		271		296		185	0	**1,38**
	FRs (times)				46		38		14		32		19	0	**14**

*** Yearly Target set by program implementers**

ADRA Nepal
Field Training Program, Kavre

ANNEX 3

Distribution of Field Training Activities by Year, '97-'02

SN	Activities	Unit	5 year Target	1st year Jul 97-Jun 98		2nd year Jul 98-Jun		3rd year Jul 99-Jun 00		4th year Jul 00-Jun		5th year Jul 01-Jun		Total	
				T	A	T	A	T	A	T	A	T	A	T	A
1	S/HP Staff Refresher Training	No.	250	47	46	24	22	50	0	52	50	52	38	**225**	**156**
2	FCHV Review Meeting (1st 6 Month)	No.		654	562	654	541	654	471	617	548	580	471		
3	FCHV Review Meeting (2nd 6 Month)	No.		654	537	654	533	654	10	617	235	580	528		
4	TBA Supervisory Meeting (1st 6 Month)	No.		485	387	485	423	485	14	485	457				
5	TBA Supervisory Meeting (2nd 6 Month)	No.		485	440	485	393	485	17	485	21				
6	Urban FCHV Review Meeting (1st 6 month)	No.										20	18		
7	Urban FCHV Review Meeting (2nd 6 month)	No.										20	18		
8	Urban TBA Supervisory Meeting (1st 6 month)	No.										27	24		
9	Urban TBA Supervisory Meeting (2nd 6 month)	No.										27	19		
10	TH Refresher Training	No.		249	189	249	196	249	181	229	184	217	172		
11	FP Counselor Initial Training (Dropout)	No.				11	10							**11**	**10**
12	FP Counselor Refresher Training	No.	56	56	56	56	56	56	56	56	55	56	0		
13	FCHVs Initial Training (Dropout)	No.						22	21	99	102			**121**	**123**
14	TBA Initial Training (Droup out)	No.								54	53			**54**	**53**

ADRA Nepal ANNEX 4

Women's Literacy Program

Summary of Literacy Program Accomplishments by Year, '97-'02

Basic Level Literacy Classes

Year	Classes	Number Enrolled	Number Completed	Dropped Out Number	Dropped Out %
1997-98	39	1170	938	232	19.8
1999-00	30	932	854	78	8.4
2000-01	20	631	628	3	0.5
2001-02*	20	644	642	2	0.3
2001-02*	20	613	612	1	0.16
Total	**129**	**3990**	**3674**	**316**	**7.9**

Reinforcing Post Literacy Level Classes (PLP)

Year	Classes	Number Enrolled	Number Completed	Dropped Out Number	Dropped Out %
1997-98	30	750	603	147	19.6
1998-99	21	600	484	116	19.3
1999-00	40	1171	1088	83	7.1
2000-01	20	601	595	6	1.0
2001-02	15	451	449	2	0.4
Total	**126**	**3573**	**3219**	**354**	**9.9**

Life Orientated Continuing Education Component (SLP)

Year	Classes	Number Enrolled	Number Completed	Dropped Out Number	Dropped Out %
2000-01	40	1221	1166	55	4.5
2001-02*	30	942	924	18	1.9
2001-02*	10	300	306	0	0.0
2001-02*	10	303	307	0	0.0
Total	**90**	**2766**	**2703**	**73**	**2.6**

* Some year dates are repeated as mult

ANNEX 5

Women's Literacy Program an Overview

Program	Basic Literacy Program	Post Literacy Program	Self Learning Program
Target Group	• Illiterate Adult Women (focused-married)	• BLP Graduates • Neo-Literate	• PLP Graduates • Open Literate women
Age Group	• 15-45 yrs. (focused 18-35yrs)	• 15-45 yrs (focused 18-35yrs)	• 15-45 yrs (focused 18-35yrs)
Group Size	• 25-30 Participants	• 20-25 Participants	• 20-30 Participants
Time Frame	• Seven months (180 contact sessions)	• Four months (100 contact sessions)	• Six days (each 15 days) (12 contact sessions)
Text/Content	• "Mahila Saksharta Pustika" HMG/BPEP-NFE Unit • Health Message Guide book ADRA-Literacy Unit	• "SAUGAT" • Health Message Guide book ADRA-Literacy Unit	• "HEAL" (12 series) World Education Nepal
Training/Orientation	• Initial Training 10 days • Refresher Training 4 days	• Initial Training 4 days • Refresher Training 2 days	• Orientation 2 days
Evaluation System	• Mid-term Exam • Final Exam	• Final Exam	• Test • Observation
Supervision/Follow-up	• Supportive Supervision • Clinical Supervision	• Supportive Supervision • Clinical Supervision	• Supportive Supervision • Follow-up
Supplies/Support	• Education Materials • Allowances	• Education Materials • Allowances	• Education Materials • Allowances

ADRA Nepal FP/PHC Centre, Banepa, Kavre **ANNEX 6**

Distribution of FP/PHC Services by Year, July 1997 to June 2002

Activities	1st Year Jul 97-Jun 98		2nd Year Jul 98-Jun 99		3rd Year Jul 99-Jun 00		4th Year Jul 00-Jun 01		5th Year Jul -Dec 01		Total Jul 97-Dec-01	
ANC: Old	3,169		3,485		4,386		4,344		4,794		20,178	
New	*1,881*		*2,185*		*2,079*		*2,003*		*2,288*		*10,436*	
Total	**5,050**		**5,670**		**6,465**		**6,347**		**7,082**		**30,614**	
TT Immunization	Preg.	N-Preg	Preg.	N-Preg	Preg.	N-Preg	Preg.	N-Preg	Preg.	N-Preg	Preg.	N-Preg
TT I							1,119	14	1,367	7	2,486	21
TT II	781	74	739	62	828	140	755	18	559	9	3,662	303
TT III							13	19	10	4	23	23
TT IV							4	16	4	12	8	28
TT V							6	2	7	11	13	13
Total	**781**	**74**	**739**	**62**	**828**	**140**	**1,897**	**69**	**1,947**	**43**	**6,192**	**388**
					Male	Female	Male	Female	Male	Female		
BCG							249	240	222	199	471	439
DPT I+Polio							468	456	460	430	928	886
Child EPI: DPT II+Polio							472	514	470	440	942	954
DPT III+Polio	480		633		272	207	488	440	444	392	2,317	1,039
Measles	500		489		283	211	200	226	217	227	1,689	664
Total	**980**		**1,122**		**555**	**418**	**1,877**	**1,876**	**1,813**	**1,688**	**6,347**	**3,982**
Under five: CDD	174		199		74	35	50	53	64	25	561	113
ARI	285		224		111	103	75	87	79	67	774	257
Growth monitoring	1,311		2,010		1,368	1,074	1,100	1,121	1,042	1,007	6,831	3,202
Malnutrition	275		429		168	123	155	144	183	146	1,210	413
Others	1,529		2,149		1,048	795	199	143	221	151	5,146	1,089
Total	**3,574**		**5,011**		**2,769**	**2,130**	**1,579**	**1,548**	**1,589**	**1,396**	**14,522**	**5,074**
STD	**402**		**412**		**11**	**445**	**13**	**249**	**9**	**208**	**847**	**902**
Infertility	47		74		14	86	9	64	15	93	38	364
Gynae PAC	5		17			16		6		6	-	50
PNC	8		141			443		380		417	-	1,389
Other	773		993			1,133		1,612		2,011	-	6,522
Total	**833**		**1,225**		**14**	**1,678**	**9**	**2,062**	**15**	**2,527**	**38**	**8,325**
FP New Acceptor												
Condoms distribution	4,290		6,160		10,735		16,190		13,648		51,023	
O.C. Pills	42		49		42		19		21		173	
Depo	815		831		713		676		467		3,502	
Norplant	548		408		599		327		238		2,120	
IUD	52		45		52		38		20		207	
Minilap	383		486		445		305		486		2,105	
Vasectomy	307		324		396		390		531		1,948	
F/P follow ups												
O.C. Pills	9		31		12		12		1		65	
Depo	184		216		179		189		182		950	
Norplant	1,250		1,025		1,119		1,142		1,069		5,605	
IUD	131		157		119		169		139		715	
Minilap	532		627		725		608		614		3,106	
Vasectomy	83		152		216		209		190		850	
Depo repeat	3,802		4,105		4,088		4,053		3,792		19,840	-
Pills repeat	42		59		91		104		76		372	-
Removal	adra	other	adra	other	adra	other	adra	other	adra	other	adra	other
Norplant	189	12	209	19	372	28	513	13	352	15	1,635	87
IUD	20	2	29	3	20	8	33	7	20	9	122	29
Others Cases	2,920		3,156		448	2,289	322	1,362	356	1,921	7,202	5,572
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
					4,409	**23,005**	**4,399**	**23,618**	**4,503**	**24,313**		
Total Services Provided	**23,017**		**26,172**		**27,414**		**28,017**		**28,816**		**133,436**	
CYP according to MOH	**13,328**		**14,230**		**15,647**		**12,293**		**15,749**		**71,247**	

Note: I TT 1-5 dose, BCG, DPT I, II and Polio were not separated during the 1-3 years period (but these numbers were included in others cases)

Note: II Male and Female cases were not separated during the 1-2 years period

ADRA Nepal FP/PHC Center, Banepa, Kavre

ANNEX 6 a

Distribution of FP/PHC services by area, July 1997 to June 2002

	Jul 97-Jun 98			Jul 98-Jun 99			Jul 99-Jun 00			Jul 00-Jun 01			Jul 01-Jun 02		
Activities	Urban	Rural	Other	Urban	Rural	Other	Urban	Rural	Other	Urban	Rural	Other	Urban	Rural	Other
ANC: Old	1,637	1,458	74	1,703	1,691	91	1,975	2,254	157	1,968	2,245	131	1,964	2,631	19
New	843	978	60	851	1,259	75	698	1,277	104	666	1,249	88	750	1,425	1
Total	***2,480***	***2,436***	***134***	***2,554***	***2,950***	***166***	***2,673***	***3,531***	***261***	***2,634***	***3,494***	***219***	***2,714***	***4,056***	***3***
TT Immunization															
TT I										447	650	36	533	786	
TT II	426	394	35	365	404	32	435	506	27	358	395	20	251	295	
TT III										18	11	3	9	4	
TT IV										13	6	1	15	1	
TT V										7	1		13	5	
Total	**426**	**394**	**35**	**365**	**404**	**32**	**435**	**506**	**27**	**843**	**1,063**	**60**	**821**	**1,091**	
BCG										339	134	16	315	96	
DPT I+Polio										594	272	58	588	256	
Child EPI: DPT III+Polio										654	274	58	624	242	
DPT III+Polio	300	171	9	362	245	26	320	129	30	620	256	52	572	238	
Measles	*314*	*170*	*16*	*331*	*143*	*15*	*341*	*131*	*22*	*301*	*106*	*19*	*322*	*116*	
Total	**614**	**341**	**25**	**693**	**388**	**41**	**661**	**260**	**52**	**2,508**	**1,042**	**203**	**2,421**	**948**	**13**
Under five:CDD	98	66	10	110	78	11	63	44	2	59	39	5	43	43	
ARI	*193*	*87*	*5*	*120*	*86*	*18*	*138*	*60*	*16*	*106*	*47*	*9*	*87*	*56*	
Growth monitoring	819	459	33	1,310	601	99	1,628	635	179	1,488	620	113	1,414	561	7
Malnutrition	138	127	10	260	136	33	204	65	22	215	69	15	246	71	1
Others	927	548	54	1,328	654	167	1,139	521	183	172	100	70	173	134	6
Total	**2,175**	**1,287**	**112**	**3,128**	**1,555**	**328**	**3,172**	**1,325**	**402**	**2,040**	**875**	**212**	**1,963**	**865**	**15**
STD	**139**	**247**	**16**	**132**	**259**	**21**	**145**	**290**	**21**	**65**	**178**	**19**	**38**	**170**	
Infertility	9	35	3	32	36	6	33	57	10	21	43	9	20	83	
Gynae PAC	2	3		4	12	1	8	7	1		6		3	3	
PNC	4	4		75	62	4	295	118	30	260	106	14	305	102	1
Other	261	483	29	328	618	47	334	716	83	417	1,114	81	534	1,368	10
Total	**276**	**525**	**32**	**439**	**728**	**58**	**670**	**898**	**124**	**698**	**1,269**	**104**	**862**	**1,556**	**12**
Family Planning	New	New	New	New	New	New	New	New	New	New	New	New	New	New	
O.C. Pills	22	20	0	23	22	4	27	12	3	11	7	1	15	6	
Depo	392	400	23	396	371	64	369	322	22	327	337	12	272	189	
Norplant	164	362	22	145	243	20	153	396	50	90	210	27	48	177	1
IUD	11	37	4	24	19	2	25	21	6	13	23	2	11	7	
Minilap	80	246	57	125	295	66	93	283	69	54	223	28	76	375	3
Vasectomy	62	193	52	56	208	60	88	268	40	59	273	58	70	383	7
F/P follow ups															
O C. Pills	2	6	1	12	17	2	9	3		7	5		1		
Depo	85	97	2	86	126	4	86	91	2	104	79	6	126	53	
Norplant	402	805	43	381	618	26	364	702	53	340	745	57	277	744	4
IUD	39	87	5	40	103	14	58	56	5	68	93	8	27	101	1
Minilap	129	346	57	197	371	59	162	467	96	122	416	70	125	447	4
Vasectomy	19	53	11	36	96	20	44	145	27	30	159	20	25	147	1
Depo repeat	2,062	1,670	70	2,152	1,856	97	2,232	1,762	94	2,308	1,664	81	2,184	1,547	6
Pills repeat	25	14	3	33	25	1	51	39	1	69	33	2	51	25	
Removal															
Norplant	73	108	20	76	137	15	159	219	22	133	362	31	91	255	2
IUD	7	14	1	17	9	6	11	15	2	13	25	2	13	15	
Others Cases	1,305	1,503	112	1,341	1,656	159	1,113	1,435	189	559	987	138	710	1,396	17
CYP according to MoH	3,407	8,338	1,583	3,961	8,474	1,795	4,058	9,844	1,745	2,808	8,191	1,293	2,946	11,236	1,56
Total Service Provided	**10,989**	**11,191**	**837**	**12,451**	**12,456**	**1,265**	**12,800**	**13,046**	**1,568**	**13,095**	**13,562**	**1,360**	**12,941**	**14,555**	**1,32**

ANNEX 7

ADRA Nepal

Comparative Distribution of FP/PHC Services, Kavre, July 1997 to June 2002

SN	Activities	Jul 97-Jun 98	Jul 98-Jun 99	Jul 99-Jun 00	Jul 00-Jun 01	Jul 01-Jun 02	Total
1	Mobile Clinic Visits	84	81	88	93	37	**383**
2	MCSC Review Meetings						**3**
3	Lab Services in MCs	130	460	828	1,216	554	**3,188**
4	ANC >=2 visit	3,503	3,845	4,957	4,940	5,062	**22,307**
5	ANC >=4 visit	-	-	-	1,866	894	**2,760**
6	ANC >= TT 2 com	781	739	828	778	580	**3,706**
7	ANC Hb% test	775	695	1,025	1,082	1,321	**4,898**
8	ANC VDRL SCR	740	684	1,026	1,067	1,321	**4,838**
9	PNC	17	180	461	391	419	**1,468**
10	STD/CM	474	446	504	308	227	**1,959**
11	Gynae/CM	1,160	1,457	1,929	2,369	2,684	**9,599**
12	Infertility/CM	49	83	105	76	109	**422**
13	PAC	6	22	16	6	6	**56**
14	CYP (MOH)	15,096	15,491	17,400	12,945	15,926	**76,858**
15	FP Camps	Complete	Complete	Complete	Complete	Complete	
16	Under 5 GM	1,311	2,010	2,442	2,221	2,049	**10,033**
17	Under 5 DPT3 com	480	633	479	464	418	**2,474**
18	Under 5 ARI/CM	369	274	257	209	164	**1,273**
19	Under 5 CDD/CM	235	256	143	125	97	**856**
20	Under 5 Malnutrition/CM	281	462	303	302	329	**1,677**

ANNEX 8

ADRA Nepal FP/MCH Mobile Clinic, Kavre
Distribution of Mobile Services, July 1997 to December 2001

Activities		1st Year Jul 97-Jun 98		2nd Year Jul 98-Jun 99		3rd Year Jul 99-Jun 00		4th Year Jul 00-Jun 01		5th Year Jul -Dec 01		Total Jul 97-Dec-01	
ANC:	Old	334		360		571		596		268		2,129	
	New	587		528		723		821		280		2,939	
	Total	**921**		**888**		**1,294**		**1,417**		**548**		**5,068**	
						Male	Female	Male	Female	Male	Female	Male	Female
Under five:	CDD	61		57		15	19	15	7	6	2	154	28
	ARI	84		50		14	29	19	28	10	8	177	65
	Growth monitoring	-		8		-	-	-	-	-	-	8	-
	Malnutrition	6		33		4	8	1	2	-	-	44	10
	Others	180		117		61	49	59	54	20	19	437	122
	Total	**331**	-	**265**	-	**94**	**105**	**94**	**91**	**36**	**29**	**820**	**225**
STD		**72**		**34**		-	**48**	-	**46**	-	**10**	106	104
Gynae	Infertility	2		9		-	5	-	3	-	1	-	20
	PAC	1		5		-	-	-	-	-	-	-	6
	PNC	9		39		-	18	-	11	-	2	-	79
	Other	315		179		-	214	-	284	-	139	-	1,131
	Total	**327**		**232**		**-**	**237**	**-**	**298**	**-**	**142**	**-**	**1,236**
FP New Acceptors													
Condoms distribution		40(2)		100(5)		60(3)		272(10)		40		512(20)	
O.C. Pills		3		7		9		5		2		26	
Depo		135		158		140		131		54		618	
Norplant		213		189		285		82		9		778	
IUD		2		-		13		12		8		35	
Minilap		23		10		3		-		-		36	
Vasectomy		19		4		4		1		1		29	
FP Follow Ups													
Condoms		-		-		-		-		-		-	-
O.C. Pills		2		2		4		3		2		13	-
Depo		50		60		72		80		24		286	-
Norplant		615		569		584		521		120		2,409	-
IUD		13		8		28		36		17		102	-
Minilap		46		66		64		46		12		234	-
Vasectomy		-		8		5		1		-		14	-
Depo repeat		421		364		372		375		159		1,691	-
Pills repeat		4		9		11		13		4		41	-
Removal		adra	other	adra	other	adra	other	adra	other	adra	other	adra	other
Norplant		57	3	38	1	113	6	193	12	36		437	22
IUD		4	-	-	1	4	1	2	1	1		11	3
Others Cases		790		586		66	756	107	799	55	259	1,604	1,814
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female		
						172	**4,149**	**213**	**4,163**	**92**	**1,436**		
Total Services Provided		**4,053**		**3,504**		**4,321**		**4,376**		**1,528**		**17,782**	
CYP according to MOH		**1,768**		**1,261**		**1,753**		**652**		**177**		**5,611**	
Total Mobile Visits		**84**		**81**		**88**		**93**		**37**		**383**	

Note: I Male and Female cases were not separated during the 1-2 year period

Note: II Mobile clinic services was closed from December 2001 due to insecurity in some areas

ADRA Nepal, FP/PHC, Banepa, Kavre **ANNEX 9**

Laboratory Units

Distribution of Lab Services by Year (Cases) July 1997 to June 2002

Cases	July 1997 to June 98	July 1998 to June 99	July 1999 to June 00	July 2000 to June 01	July 01 to June 2002	Total
Antenatal	775	744	1,072	991	1,255	**4,837**
Minilap	480	483	1,181	406	612	**3,162**
Vasectomy	380	399	626	586	768	**2,759**
Fertility	715	892	1,217	922	1,294	**5,040**
CLPP	121	282	304	315	183	**1,205**
PHC	1,188	731	831	1,054	1,568	**5,372**
Others	1,533	1,143	575	391	414	**4,056**
Total	**5,192**	**4,674**	**5,806**	**4,665**	**6,094**	**26,431**

Distribution of Lab services by Year (Tests) July 1997 to June 2002

Test	July 1997 to June 98	July 1998 to June 99	July 1999 to June 00	July 2000 to June 01	July 01 to June 2002	Total
Hematology	3,628	2,767	3,450	2,861	4,837	**17,543**
Virology	2,564	2,507	3,160	3,314	3,663	**15,208**
Biochemistry	2,683	1,902	1,290	2,139	1,920	**9,934**
Bacteriology	1,196	431	110	228	552	**2,517**
Semen Analysis	*106*	*147*	*166*	*195*	*259*	***873***
Urine Analysis	3,034	3,161	4,763	4,213	5,362	**20,533**
Stool Analysis	715	767	1,048	1,202	1,352	**5,084**
Total	**13,926**	**11,682**	**13,987**	**14,152**	**17,945**	**71,692**

Mobile Clinic Laboratory Services

Four and a Half Years (Cases) Achievement July 1997 to December 2001

Cases	July 1997 to June 98	July 1998 to June 99	July 1999 to June 00	July 2000 to June 01	July to Dec. 2001	Total
Antenatal	6	76	127	206	86	**501**
Minilap	13	-	6	-	-	**19**
Vasectomy	15	2	11	2	-	**30**
Fertility	63	84	132	129	67	**475**
Others	6	47	91	146	58	**348**
Total	**103**	**209**	**367**	**483**	**211**	**1,373**

Mobile Clinic Laboratory Services

Four and a Half Years (Tests) Achievement July 1997 to December 2001

Test	July 1997 to June 98	July 1998 to June 99	July 1999 to June 00	July 2000 to June 01	July to Dec. 2001	Total
Hematology	22	84	155	218	94	**573**
Virology	2	141	254	410	171	**978**
Biochemistry	-	5	10	20	3	**38**
Bacteriology	-	-	2	2	-	**4**
Semen Analysis	-	2	6	3	-	**11**
Urine Analysis	106	166	318	426	210	**1,226**
Stool Analysis	-	62	83	137	76	**358**
Total	**130**	**460**	**828**	**1,216**	**554**	**3,188**

ADRA Nepal **ANNEX 10**

Integrated Community-Based Family Health Program, 1997-2002

Key Health and Population Indicators, 2054 to 2058, BS, Program Area , Kavre

Indicators	2054		2055		2056		2057		2058	
	#	%	#	%	#	%	#	%	#	%
Married Women of Reproductive Age (MWRA)	**42,484**		**46,546**		**49,158**		**52,468**		**53,529**	
Total FP Users	23,097		26,779		28,914		31,454		32,846	
Contraceptive Prevalence Rate (CPR)		**54.4**		**57.5**		**58.8**		**59.9**		**61.4**
Family Planning										
Permanent Methods										
Male	5,298	12.5	5,754	12.4	6,282	12.8	6,834	13	7,078	13.2
Female	6,160	14.5	6,957	14.9	7,493	15.2	8,062	15.4	8,463	15.8
Total	**11,458**	**27**	**12,711**	**27.3**	**13,775**	**28.0**	**14,896**	**24.8**	**15,541**	**29**
Temporary Methods										
Pills	736	1.7	740	1.6	715	1.5	792	1.5	822	1.5
Condom	1,000	2.4	1,331	2.8	1,229	2.5	1,307	2.5	1,408	2.6
Depo	7,522	17.7	9,427	20.3	10,457	21.3	11,552	22	12,209	22.8
Norplant	2,079	4.9	2,249	4.8	2,373	4.8	2,490	4.7	2,386	4.5
IUD	302	0.7	322	0.7	365	0.7	417	0.8	424	0.8
Temporary Total	**11,639**	**27.4**	**14,069**	**30.2**	**15,139**	**30.8**	**16,558**	**31.6**	**17,249**	**32.2**
ANC check up by (out of pregnancy outcome)										
TBAs			767	20.1	575	14.3	1,184	28.7	1,092	30
TBAs and Health Person	1,796	63	2,853	74.6	3,348	83	3,578	86.7	3,089	84
TT dose>=2	1,886	67	3,156	82.5	3,563	88.3	3,771	91.4	3,383	92
Delivery Assisted by (out of live birth+still birth)										
TBAs			1,131	29.8	1,175	29.5	1,190	29.1	979	27
Health Person	1,498	44	853	22.5	1,061	26.7	1,312	32.1	1,325	36
Others			1,810	47.7	1,763	44.3	1,582	38.7	1,357	37
Pregnancy out come										
Live Birth	3,360	98.5	3,735	97.7	3,906	96.8	4,011	97.2	3,618	98
Still Birth	33	0.9	62	1.6	73	1.8	81	2	39	1
Abortion	15	0.4	27	0.7	55	1.5	33	0.8	22	1
PNC check up by (out of pregnancy outcome)										
TBAs			447	11.7	344	8.5	1,086	26.3	929	25
TBAs and Health person			789	20.6	886	22	2,524	61.2	2,263	62
TFR Per MWRA		2.6		2.6		2.6		2.6		2.6
GFR Per one thousand MWRA		79		80		79		76		67.6
NMR Per one thousand live births	42	12.5	46	12.3	61	15.6	64	16	27	7.5
IMR Per one thousand live births	64	19	64	17.1	20	75	75	18.7	54	14.9
MMR Per one hundred thousand live births	3	89.3	1	26.8	3	76.8	4	99.7	3	82.9

ANC = Antenatal Care, PNC = Post Natal Care, TFR = Total Fertility Rate, GFR = General Fertility Rate

NMR = Neonatal Mortality, IMR = Infant Mortality, MMR = Maternal Mortality

ADRA Nepal **ANNEX 10 a**

Integrated Community-Based Family Health Program, 1997-2002

Key Health and Population Indicators 2058 BS Kavre Program Area and Kavre, Rasuwa and National Status

Indicators	ADRA Working Area		Kavre	Rasuwa	National
	#	%			
Married Women of Reproductive Age (MWRA)	53,529		71,541*	8,261*	4,409,900*
Total FP Users	32,846		34,326*	2,882*	1,524,408*
Contraceptive Prevalence Rate (CPR)		**61**	**48.18***	**34.88***	**39.3****
Family Planning					
Permanent Methods					
Male	7,078	13			7.0**
Female	8,463	16			16.5**
Total	**15,541**	**29**	**19.9***	**21.2***	**23.5****
Temporary Methods					
Pills	822	2	1.3*	1.8*	1.8**
Condom	1,408	3	2.03*	3.02*	3.2**
Depo	12,209	23	19.2*	5.2*	9.3**
Norplant	2,386	5	5.1*	3.7*	0.7**
IUD	424	1	0.7*	0*	0.4**
Total	**17,249**	**32**	**28**	**13.7***	**15.4****
ANC Check up by (out of pregnancy outcome)					
TBAs	1,092	30			
TBAs and Health Person	3,089	84	43*	17.5*	49**
TT dose>=2	3,383	92			45**
Delivery Assisted by (out of live birth+still birth)					
TBAs	979	27	49*	35*	23**
Health Person	1,325	36	6*	8.1*	13**
Others	1,357	37			55**
Pregnancy Out come					
Live Birth	3,618	98			92.3**
Still Birth	39	1			2.1**
Abortion	22	1			5.5**
PNC Check up by (out of pregnancy outcome)					
TBAs	929	25			
TBAs and Health Person	2,263	62	9.3*	12.2*	9.4*
TFR Per MWRA		3			4.58*
GFR Per one thousand MWRA		68			
NMR Per one thousand live birth	27	8			39**
IMR Per one thousand live birth	54	15			64**
MMR Per one hundred thousand live birth	3	83			47.5*

ANC = Antenatal Care, PNC = Post Natal Care, TFR = Total Fertility Rate, GFR = General Fertility Rate

NMR = Neonatal Mortality, IMR = Infant Mortality, MMR = Maternal Mortality

** DoHS Annual Report, 2056/57 (1999/2000)*

*** Demographic and Health Survey 2001*

ANNEX 11

VDC Health Empowerment Activities, Kavre
Summary of Five Year Program
July 1997 to June 2002

SN	Activities	Unit	5 YT	Jul 97-Jun 98		Jul 98-Jun 99		Jul 99-Jun 00		Jul 00-Jun 01		Jul 01-Jun 02		Total	
				T	A	T	A	T	A	T	A	T	A	T	A
1	TOT to S/HPSC Trainers	Batch				1	1							1	1
2	VDC Health Empowerment Workshop	Times						2	2					2	2
3	S/HPSC Formation	S/HPSC		11	8	12	7	12	23	7	4		1	42	43
4	S/HPSC Pre-training Meeting	S/HPSC		11	8	12	7	12	21	7	6		1	42	43
5	S/HPSC Initial Training (5 days)	S/HPSC	46	11	8	12	7	12	23	7	4		1	42	43
6	S/HPSC Monthly Meeting	Number		82	9	30	18	147	127	517	301	318	248	1,094	703
7	Support S/HPSC Monthly Meeting	Number		82	9	30	18	147	127	475	228	256	180	990	562
8	S/HPSC Four Monthly Joint Meeting	Number		14	8	19	19	57	44	125	64	66	41	281	176
9	Support S/HPSC Four Monthly Joint Meeting (1st)	Number								44	33	33	18	77	51
10	Support S/HPSC Four Monthly Joint Meeting (2nd)	Number								41	24	33	23	74	47
11	Support S/HPSC Four Monthly Joint Meeting (3rd)	Number								40	7			40	7
12	Support Annual Review and Planning Meeting (1st yr)	Number				5	5	19	14	22	20	7	7	53	46
13	Support Annual Review and Planning Meeting (2nd yr)	Number								18	14	17	12	35	26
14	Support Annual Review and Planning Meeting (3rd yr)	Number										14	12	14	12
15	Orientation to S/HPSC	Number	4	4	4										

*** 4 VDCs (Baluwa, Shankhu, Khanalthok & Mahendrajyoti) training was completed before implementing the FHP Program.**

*** Yearly Target set by program implementers** **Note: T= Target, A= Achievement**

ADRA Nepal

ANNEX 12

Field Program, '97-'02, Rasuwa

SN	Activities	Units	5 YT	Y1		Y2		Y3		Y4		Y5		Total	
				T	A	T	A	T	A	T	A	T	A	T	A
1	**VDC Health Empowerment**														
	VDC Health Empowerment Workshop	Time								1	1			1	1
	S/HPSC Formation Restructure	VDCs						8	5	10	12		1	18	18
	S/HPSC Pre-training Meeting	VDCs						8	5	10	12		1	18	18
	S/HPSC Initial Training	VDCs	17					8	5	10	12	0	1	18	18
	S/HPSC Monthly Meeting	Number								85	58	121	72	206	130
	Support S/HPSC Monthly Meeting	Number						24	17	15	41	37	37	76	95
	S/HPSC Four Monthly Joint Meeting	Number						5	4	24	15	26	18	55	37
	Support in First Four Monthly Joint Meeting	Number						5	4	14	9	19	8	38	21
	Support in Second Four Monthly Joint Meeting	Number								3	5	8	10	11	15
	Support S/HPSC Annual Review and Planning Meeting	Number								5	5	8	7	13	12
	Support S/HPSC Annual Review and Planning Meeting	*Number*										3	2	3	2
2	**Community Health Program**														
	Community Volunteers Visit	Number					373	180	209					180	582
	FCHVs Follow up (Non-ARI)	Number						36	44	41	43	66	57	143	144
	TBAs Follow up	Number						*18*	*28*	*30*	*34*	*31*	*29*	79	91
	TBA/FCHVs Follow up	Number								1	7	13	9	14	16
	TH Follow up	Number						25	24	24	27	26	22	75	73
	Under 5 Child Bearing Mother Follow up	Number						73	85	70	78	70	61	213	224
	Attend Mother Group Meeting	Group		121	39	62	34	50	50	41	18	39	30	313	171
	Health Quiz Contest	Number	162					54	61	101	66	26	35	181	162
	Co-ordination with S/HP/NGOs	Time				11	18	24	18	21	20	8	14	64	70
	Support to Mobile Clinic	Time							9	17	11	0	0	17	20
	National Health Days Celebration (every year)	Time		5	2	5	5	4	4	4	4	1	4	19	19
	Support National Vitamin 'A' Program	Time								0	2	2	2	2	4
	Support Street Drama	No.	25		11				11			4	0	4	22
3	**Community Health Training/Orientation/Review Meeting**													0	0
	S/HP Staff Refresher Training	Number	125	25	0	25	26	25	28	25	29	25		125	83
	FCHV Review Meeting (ADRA)	Number						245	204	245	221	224	224		
	Support to FCHV Review Meeting Conduct by (DHO)	VDCs		6	6	8	8	18	18	18	18	18	18		
	Dropout FCHV Initial Training	Number								80	78			80	78
	FCHV TOT Training to ADRA and DHO Staff	Batch				23	23							23	23
	Support TBA Supervisory Meeting Conduct by (DHO)	VDCs			4		4	4	4						
	VDC Health orientation	VDCs		4	4	14	8	5	5	1	0			24	17
	Health Education Orientation	VDCs			3	15	9	4	6					19	18
	TBA Orientation to ADRA Staff	Batch						1	1					1	1
	Co-ordination with DHO	Time		4	4	4	4	1	1					9	9
4	**Supported in ARI Activities**														
	ARI TOT All Level	VDCs				18	18							18	18
	ARI FCHVs Initial Training	VDCs				18	18							18	18
	ARI Checklist	Number						168	179	240	215			408	394
	ARI FCHVs Follow up	Number						252	230	240	253	59	59	551	542
	VHW/MCHW follow-up	Number						44	32	27	26			71	58
	VHW Follow up	Number										6	6	6	6
	MCHW Follow up	*Number*										5	5	5	5
	Heath Facility Follow up	Number						44	40	21	24	19	19	84	83
	Co-ordination with JSI/DHO Reg. ARI	Number										2	2	2	2
	Involve in ARI Monitoring meeting	Time									129			0	129

ADRA Nepal

Women's Health Literacy Program, Rasuwa **ANNEX 13**

Basic Level Literacy (BLL)

SN	Years	Centers	Enrolled	Completed	Dropout	Dropout %
1	1997/98	21	503	338	165	32.8
2	1998/99	21	496	444	52	10.5
3	1999/00	21	567	450	117	20.6
4	2000/01	15	402	385	17	4.2
	2001/02	14	279	278	1	0.4
	Total	**92**	**2247**	**1895**	**352**	

Reinforcing Post Level Literacy (RPLL)

SN	Year	Centers	Enrolled	Completed	Dropout	Dropout %
1	1998/99	13	243	193	50	20.6
2	1999/00	15	346	320	26	7.5
3	2001/02	15	302	293	9	3.0
	2001/02	12	204	201	3	1.5
	Total	**55**	**1095**	**1007**	**88**	

Life Oriented Continued Education Component (LOCEC)

SN	Year	Centers	Enrolled	Completed	Dropout	Dropout %
1	2001/02	52	1194	1173	21	1.8
	Total	**52**	**1194**	**1173**	**21**	

ADRA Nepal FP/PHC Clinic, Kalikasthan, Rasuwa **ANNEX 14**

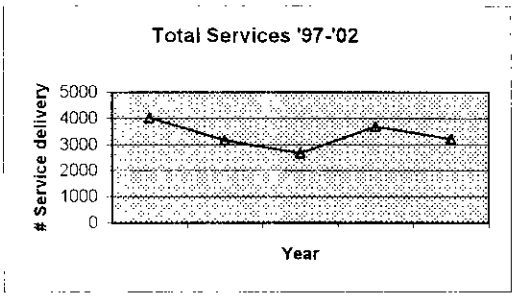
Distribution of FP/PHC Services Kalikasthan, July 1997 to June 2002

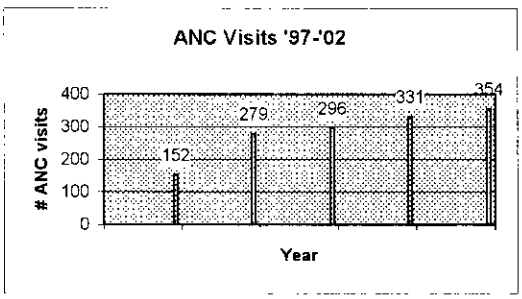
Activities	1st Year Jul 97-Jun 98		2nd Year Jul 98-Jun 99		3rd Year Jul 99-Jun 00		4th Year Jul 00-Jun 01		5th Year Jul -Dec 01		Total Jul 97-Dec-01	
ANC: Old	72		161		174		150		205		762	
New	80		118		122		181		149		650	
Total	**152**		**279**		**296**		**331**		**354**		1,412	
TT Immunization	Preg.	N-Preg	Preg.	N-Preg	Preg.	N-Preg	Preg.	N-Preg	Preg.	N-Preg	Preg.	N-Preg
TT I							41	27	40	38	81	65
TT II	21	13	27	23	33	28	24	18	29	30	134	112
TT III							-	12	1	24	1	36
TT IV								2	1	6	1	8
TT V								5	2	13	2	18
Total	**21**	**13**	**27**	**23**	**828**	**140**	**65**	**64**	**73**	**111**	**219**	**239**
					Male	Female	Male	Female	Male	Female		
BCG							12	8	14	19	26	27
DPT I+Polio							15	15	12	19	27	34
Child EPI: DPT II+Polio							21	11	8	11	29	22
DPT III+Polio	12		6		9	3	16	10	11	11	54	24
Measles	4		10		6	5	20	14	7	13	47	32
Total	**16**		**16**		**15**	**8**	**84**	**58**	**52**	**73**	183	139
Under five: CDD	142		104		31	24	32	31	24	20	333	75
ARI	192		76		48	21	51	42	32	28	399	91
Growth monitoring	8		335		170	94	221	128	186	123	920	345
Malnutrition	18		87		46	55	65	50	75	51	291	156
Others	374		338		114	63	104	91	77	62	1,007	216
Total	**734**		**940**		**409**	**257**	**473**	**342**	**394**	**284**	2,950	883
STD		**49**		**65**	**1**	**39**	**4**	**87**	**3**	**68**	8	308
Gynae Infertility				5		2	3	12	1	4	4	23
PAC				14		3		5		-	-	22
PNC				3		11		13		21	-	48
Other		69		127		72		242		156	-	666
Total		**69**		**149**	-	**88**	**3**	**272**	**1**	**181**	**4**	759
FP New Acceptor												
Condoms distribution		500		1,500		2,360		5,380		10,805		20,545
O.C. Pills		2		7		2		4		1		16
Depo		68		64		78		51		57		318
Norplant		54		34		64		66		26		244
IUD				3		1		23		10		37
Minilap				-		29		12		-		41
Vasectomy				-		5		5		2		12
F/P follow ups												
O.C. Pills		4						1				5
Depo		21		22		10		9		7		69
Norplant		208		174		109		121		121		733
IUD		-		-		-		25		17		42
Minilap		26		21		43		24		21		135
Vasectomy		1		5		6		15		9		36
Depo repeat		151		237		311		355		420	1,474	-
Pills repeat		6		2		7		3		5	23	-
Removal	adra	other	adra	other	adra	other	adra	other	adra	other	adra	other
Norplant	13		25	-	17	1	48	1	71	2	174	4
IUD			-	-	-	-	3	2	3	-	6	2
Others Cases		2,303		1,078	464	344	492	641	374	468	4,711	1,453
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
					900	1,765	1,076	2,608				
Total Services Provided		**4,018**		**3,171**		**2,665**		**3,684**		**3,209**		**16,747**
CYP according to MOH		**330**		**281**		**885**		**874**		**429**		2,799

Note: I TT 1-5 dose, BCG, DPT I, II and Polio were not separated during the 1-3 years period
(but these numbers were included in others cases)

Note: II Male and Female cases were not separated during the 1-2 years period

97-'98	152	####
98-'99	279	####
99-'00	296	####
00-'01	331	####
01-'02	354	####





ADRA Nepal FP/PHC Clinic, Kalikasthan, Rasuwa

ANNEX 14 a

Five Year Service Statistics Report July 1997 to June 2002

Activities		1st Year Jul 97-Jun 98		2nd Year Jul 98-Jun 99		3rd Year Jul 99-Jun 00		4th Year Jul 00-Jun 01		5th Year Jul -Dec 01		Total Jul 97-Dec-01	
ANC:	Old		72		161		174		150		205		762
	New		80		118		122		181		149		650
	Total		**152**		**279**		**296**		**331**		**354**		**1,412**
TT Immunization		Preg.	N-Preg	Preg.	N-Preg	Preg.	N-Preg	Preg.	N-Preg	Preg.	N-Preg	Preg.	N-Preg
TT I								**41**	27	40	38	81	65
TT II		21	13	27	23	33	28	24	18	29	30	134	112
TT III								-	12	1	24	1	36
TT IV									2	1	6	1	8
TT V									5	2	13	2	18
	Total	**21**	**13**	**27**	**23**	**828**	**140**	**65**	**64**	**73**	**111**	**219**	**239**
						Male	Female	Male	Female	Male	Female		
	BCG							12	8	14	19	26	27
	DPT I+Polio							15	15	12	19	27	34
Child EPI:	**DPT II+Polio**							21	11	8	11	29	22
	DPT III+Polio	12		6		9	3	16	10	11	11	54	24
	Measles	4		10		6	5	20	14	7	13	47	32
	Total	**16**		**16**		**15**	**8**	**84**	**58**	**52**	**73**	**183**	**139**
Under five:	**CDD**	142		104		31	24	32	31	24	20	333	75
	ARI	192		76		48	21	51	42	32	28	399	91
	Growth monitoring	8		335		170	94	221	128	186	123	920	345
	Malnutrition	18		87		46	55	65	50	75	51	291	156
	Others	374		338		114	63	104	91	77	62	1,007	216
	Total	**734**		**940**		**409**	**257**	**473**	**342**	**394**	**284**	**2,950**	**883**
STD			**49**		**65**	**1**	**39**	**4**	**87**	**3**	**68**	8	308
	Infertility				5		2	3	12	1	4	4	23
Gynae	**PAC**				14		3		5		-	-	22
	PNC				3		11		13		21	-	48
	Other		69		127		72		242		156	-	666
	Total		**69**		**149**	**-**	**88**	**3**	**272**	**1**	**181**	**4**	**759**
FP New Acceptor													
	Condoms distribution		500		1,500		2,360		5,380		10,805		20,545
	O.C. Pills		2		7		2		4		1		16
	Depo		68		64		78		51		57		318
	Norplant		54		34		64		66		26		244
	IUD				3		1		23		10		37
	Minilap				-		29		12		-		41
	Vasectomy				-		5		5		2		12
F/P follow ups													
	O.C. Pills		4						1				5
	Depo		21		22		10		9		7		69
	Norplant		208		174		109		121		121		733
	IUD		-		-		-		25		17		42
	Minilap		26		21		43		24		21		135
	Vasectomy		1		5		6		15		9		36
	Depo repeat		151		237		311		355		420	1,474	-
	Pills repeat		6		2		7		3		5	23	-
	Removal	adra	other	adra	other	adra	other	adra	other	adra	other	adra	other
	Norplant	13		25	-	17	1	48	1	71	2	174	4
	IUD			-	-	-	-	3	2	3	-	6	2
	Others Cases	2,303		1,078		464	344	492	641	374	468	4,711	1,453
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
						900	**1,765**	**1,076**	**2,608**				
Total Services Provided			**4,018**		**3,171**		**2,665**		**3,684**		**3,209**		**16,747**
CYP according to MOH			**330**		**281**		**885**		**874**		**429**		**2,799**

Note: I TT 1-5 dose, BCG, DPT I, II and Polio were not separated during the 1-3 years period

Note: II Male and Female cases were not separated during the 1-2 years period

ADRA Nepal FP/MCH Mobile Clinic, Rasuwa

Distribution of Mobile Services, May 1998 to December 2001

ANNEX 15

Activities	1st Year May-Jun 98		2nd Year Jul 98-Jun 99		3rd Year Jul 99-Jun 00		4th Year Jul 00-Jun 01		5th Year Jul -Dec 01		Total May 1998-Dec-01	
ANC: Old	18		13		55		71		18		175	
New	3		34		53		75		11		176	
Total	**21**		**47**		**108**		**146**		**29**		**351**	
					Male	Female	Male	Female	Male	Female	Male	Female
Under five: CDD	11		10		17	12	12	21	3	10	53	43
ARI	15		13		18	16	19	16	10	12	75	44
Growth monitoring	-		-				13	16	36	44	49	60
Malnutrition	1		4				4	6	11	26	20	32
Others	19		44		34	50	53	49	23	25	173	124
Total	**46**		**71**		**69**	**78**	**101**	**108**	**83**	**117**	**370**	**303**
STD	**9**		**12**		**1**	**17**	**1**	**11**		**9**	2	58
Infertility						2		1			-	3
Gynae PAC											-	-
PNC			4			17		36		10	-	67
Other	6		8			33		55		16	-	118
Total	**6**		**12**		-	**52**	-	**92**	-	**26**	-	**188**
FP New Acceptor												
Condoms distribution												
O.C. Pills			2					2				4
Depo	1		11			33		42		10		97
Norplant			24			60		74		18		176
IUD								6		1		7
Minilap												-
Vasectomy												-
FP Follow Ups												
Condoms											-	
O.C. Pills											-	
Depo			2			5				5	12	
Norplant			13			131		124		46	314	
IUD								2		2	4	
Minilap								2			2	
Vasectomy											-	
Depo repeat			2			45		125		46	218	
Pills repeat								3		1	4	
Removal	adra	other	adra	other	adra	other	adra	other	adra	other	adra	other
Norplant					1	1		6	3		4	7
IUD								1	2		2	1
Others Cases	138		159		124	263	117	270	52	108	590	641
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female		
					194	**794**	**219**	**1,014**	**135**	**423**		
Total Services Provided	**221**		**355**		**988**		**1,233**		**558**		**3,355**	
CYP according to MOH			**113**		**322**		**463**		**112**		**1,010**	
Total Mobile Visit	**3**		**20**		**28**		**33**		**9**		**93**	

Note: I Male and Female cases was not separated during the 1-2 year period

Note: II Mobile clinic services was closed from December 2001

Note: III ADRA's Mobile clinic has been started from May 1998 in Rasuwa

ADRA Nepal FP/MCH Mobile Clinic, Rasuwa

ANNEX 15 a

Distribution of Mobile Services by Year, Rasuwa, May 1998 to December 2001

Activities		1st Year May-Jun 98		2nd Year Jul 98-Jun 99		3rd Year Jul 99-Jun 00		4th Year Jul 00-Jun 01		5th Year Jul -Dec 01		Total May 1998-Dec-01	
ANC:	**Old**	18		13		55		71		18		17	
	New	3		34		53		75		11		17	
	Total	**21**		**47**		**108**		**146**		**29**		**35**	
						Male	Female	Male	Female	Male	Female	Male	Female
Under five:	**CDD**	11		10		17	12	12	21	3	10	53	4
	ARI	15		13		18	16	19	16	10	12	75	4
	Growth monitoring	-		-				13	16	36	44	49	6
	Malnutrition	1		4				4	6	11	26	20	3
	Others	19		44		34	50	53	49	23	25	173	12
	Total	**46**		**71**		**69**	**78**	**101**	**108**	**83**	**117**	**370**	**30**
	STD	**9**		**12**		**1**	**17**	**1**	**11**		**9**	2	5
	Infertility						2		1			-	
Gynae	**PAC**											-	-
	PNC			4			17		36		10	-	6
	Other	6		8			33		55		16	-	11
	Total	**6**		**12**		**-**	**52**	**-**	**92**	**-**	**26**	-	**18**
FP New Acceptors													
Condoms distribution													
O.C. Pills				2				2					
Depo		1		11		33		42		10			9
Norplant				24		60		74		18			17
IUD								6		1			
Minilap													-
Vasectomy													-
FP Follow Ups													
Condoms												-	
O.C. Pills												-	
Depo				2		5				5		12	
Norplant				13		131		124		46		314	
IUD								2		2		4	
Minilap								2				2	
Vasectomy												-	
Depo repeat				2		45		125		46		218	
Pills repeat								3		1		4	
Removal		adra	other	adra	other	adra	other	adra	other	adra	other	adra	other
Norplant						1	1		6	3		4	
IUD									1	2		2	
Others Cases		138		159		124	263	117	270	52	108	590	64
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female		
						194	**794**	**219**	**1,014**	**135**	**423**		
Total Services Provided			**221**		**355**		**988**		**1,233**		**558**		**3,35**
CYP according to MOH					**113**		**322**		**463**		**112**		**1,01**
Total Mobile Visits			**3**		**20**		**28**		**33**		**9**		**9**

Note: I Male and Female cases were not separated during the 1-2 year period

Note: II Mobile clinic services were closed from December 2001

Note: III ADRA's Mobile clinic started from May 1998 in Rasuwa